Preferred Blue
Master Group Policy
And
Enrollee Certificate

GROUP POLICY

FOR

State of Idaho

Group #10040000

Effective Date: July 1, 2005

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PREFERRED BLUE MASTER GROUP POLICY BENEFITS OUTLINE

This Benefits Outline describes the benefits of this Policy in general terms. It is important to read the Policy in full for specific and detailed information that includes additional exclusions and limitations on benefits. The Office of Group Insurance will be able to help if you have questions.

Throughout this Policy, Blue Cross of Idaho may be referred to as BCI. For Covered Services under the terms of this Policy, Maximum Allowance is the amount established by BCI as the highest level of compensation for a Covered Service. There is more detailed information on how Maximum Allowance is determined and how it affects out-of-state coverage in the Definitions Section.

To locate a Contracting Provider in your area, please visit our Web site at www.bcidaho.com. The Provider Directory is located on the left side of the page. Click on the "Search" button directly under "Provider Directory" and you will be taken to our searchable Directory. You may also call our Customer Services Department at 1-208-331-8897 or 1-866-804-2253 for assistance in locating a Provider.

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ELIGIBILITY AND ENROLLMENT

Eligible Employees are officers or employees of state agencies, departments, or institutions, including state officials, elected officials, or employees of other governmental entities which have contracted with the State of Idaho for medical expense coverage, who are working twenty (20) hours or more per week, or eighty-four (84) hours per month, and whose term of employment is expected to exceed five (5) months in any consecutive twelve (12) month period.

Employees hired on or after the effective date of this Policy will have coverage for him or herself and any enrolled Dependent(s) effective the first day of the month following ninety (90) days of employment, provided enrollment is completed within sixty (60) days of the date of hire. The following exception applies: Benefits for employees rehired within twelve (12) months of the last date of employment who were eligible for benefits when last employed by the State, will be effective on the first day of the month following the date of rehire.

(see the Policy for additional Eligibility and Enrollment provisions)

Note: In order to receive benefits, some Covered Services require Prior Authorization. Please review the "Services Requiring Prior Authorization Notice" attached to this Benefits Outline for more specific details.

Insureds should check with BCI to determine if the treatment or service being considered requires Prior Authorization. All Inpatient Admissions and Emergency Admissions require Inpatient Notification Review or Emergency Admission Review, as appropriate.

If an Insured chooses a Noncontracting or a nonparticipating Provider, the Insured may be responsible for any charges that exceed BCI's Maximum Allowance.

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COMPREHENSIVE MAJOR MEDICAL BENEFITS		
Deductibles:	**In-Network**	**Out-of-Network**
• Individual	Insured pays first $250 of eligible expenses per Benefit Period, except for specifically listed In-Network Wellness/Preventive Care Services, Physician office visits, and preventive screening mammogram services	Insured pays first $500 of eligible expenses per Benefit Period
• Family	Insureds pay a combination of $750 of eligible expenses for all Insureds under same Family Coverage per Benefit Period, except for specifically listed In-Network Wellness/Preventive Care Services, Physician office visits, and preventive screening mammogram services *(No Insured may contribute more than the Individual Deductible amount toward the Family Deductible.)*	Insureds pay a combination of $1,500 of eligible expenses for all Insureds under same Family Coverage per Benefit Period *(No Insured may contribute more than the Individual Deductible amount toward the Family Deductible.)*
Out-of-pocket Limit – ***Coinsurance plus Deductible***	**In-Network**	**Out-of-Network**
• Individual	Insured pays $3,250 of eligible expenses per Benefit Period	Insured pays $6,500 of eligible expenses per Benefit Period
• Family	Insureds pay a combination of $6,750 of eligible expenses per Benefit Period	Insureds pay a combination of $13,500 of eligible expenses per Benefit Period
Out-of-pocket expenses associated with the following are not included in the Out-of-pocket Limit: • Amounts that exceed the Maximum Allowance. • In-Network Copayments. • Amounts that exceed benefit limits. • Dental Covered Services, except Dental Services Related to Accidental Injury.	*When the Out-of-pocket Limit is met, benefits payable for Covered Services increases to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for Wellness Covered Services, Physician office visits,*	*When the Out-of-pocket Limit is met, benefits payable for Covered Services increases to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for dental covered services, vision care, Prescription Drug Covered*

• Vision care Covered Services. • Prescription Drug Covered Services. • Noncovered services or supplies. • Mental health and substance abuse services.	*preventive screening mammogram services, dental covered services, vision care, Prescription Drug Covered Services, mental health and substance abuse services, and amounts exceeding benefit limits.* **(No Insured may contribute more than the Individual Out-of-pocket Limit toward the Family Out-of-pocket Limit.)**	*Services, mental health and substance abuse services, and amounts exceeding benefit limits.* **(No Insured may contribute more than the Individual Out-of-pocket Limit toward the Family Out-of-pocket Limit.)**
Comprehensive Lifetime Benefit Limit	BCI pays up to $1,000,000 on behalf of an Insured for all combined Covered Services. Payments applied toward specific Lifetime Benefit Limits also apply toward the all-inclusive Comprehensive Lifetime Benefit Limit.	

CS1 PPO wMA/01/02

SERVICES BCI COVERS	***AMOUNT OF PAYMENT***	
Ambulance Transportation Service	**In-Network** BCI pays 85% of Maximum Allowance after Deductible	**Out-of-Network** BCI pays 70% of Maximum Allowance after Deductible
Chiropractic Care Service	**In-Network** BCI pays 85% of Maximum Allowance after Deductible	**Out-of-Network** BCI pays 50% of Maximum Allowance after Deductible
	up to a combined total of $500 per Insured, per Benefit Period	
Dental Services Related to Accidental Injury • For covered services received within 12 months of the injury	**In-Network** BCI pays 85% of Maximum Allowance after Deductible	**Out-of-Network** BCI pays 70% of Maximum Allowance after Deductible
Diagnostic Services	**In-Network** BCI pays 85% of Maximum Allowance after Deductible	**Out-of-Network** BCI pays 70% of Maximum Allowance after Deductible

CS1 PPO wMA/01/02

SERVICES BCI COVERS	***AMOUNT OF PAYMENT***	
Durable Medical Equipment **Orthotic Devices** **Prosthetic Appliances**	**In-Network** BCI pays 85% of Maximum Allowance after Deductible	**Out-of-Network** BCI pays 70% of Maximum Allowance after Deductible
Emergency Services *(for services and conditions that affect continuing benefit payments see Emergency Services under Additional Amount of Payment in the Comprehensive Major Medical Benefits Section of this Policy)*	**In-Network** BCI pays 85% of Maximum Allowance after Deductible	**Out-of-Network** BCI pays 70% of Maximum Allowance after Deductible
Home Health Skilled Nursing Care Services	**In-Network** BCI pays 85% of Maximum Allowance after Deductible	**Out-of-Network** BCI pays 70% of Maximum Allowance after Deductible
	up to a combined total of $5,000 per Insured, per Benefit Period	
Hospice Services	**In-Network** BCI pays 100% of Maximum Allowance (Deductible does not apply) (Lifetime Benefit Limit is $5,000 per Insured)	**Out-of-Network** No benefits
Hospital Services • Includes coverage for newborn nursery charges	**In-Network** BCI pays 85% of Maximum Allowance after Deductible	**Out-of-Network** BCI pays 70% of Maximum Allowance after Deductible
Human Growth Hormone Therapy	**In-Network** BCI pays 85% of Maximum Allowance after Deductible	**Out-of-Network** BCI pays 70% of Maximum Allowance after Deductible
Inpatient Physical Rehabilitation Care	**In-Network** BCI pays 85% of Maximum Allowance after Deductible (Lifetime Benefit Limit is $150,000 per Insured)	**Out-of-Network** No benefits
Mammography Services • Preventive Screening Services • Diagnostic Services	**In-Network** Insured pays $20 Copayment BCI pays 85% of Maximum Allowance after Deductible	**Out-of-Network** BCI pays 70% of Maximum Allowance after Deductible

SERVICES BCI COVERS	***AMOUNT OF PAYMENT***	
Maternity Services	**In-Network** BCI pays 85% of Maximum Allowance after Deductible	**Out-of-Network** BCI pays 70% of Maximum Allowance after Deductible
Outpatient Diabetes Education • Only for Providers approved by BCI	**In-Network** BCI pays 85% of Maximum Allowance after Deductible (up to $500 per Insured, per Benefit Period)	**Out-of-Network** No benefits
Outpatient Rehabilitation Therapy Services • Outpatient Occupational Therapy • Outpatient Physical Therapy • Outpatient Speech Therapy	**In-Network** BCI pays 50% of Maximum Allowance after Deductible (up to combined total of $2,000 per Insured per Benefit Period)	**Out-of-Network** No benefits
Physician Office Visits	**In-Network** Insured pays **$**20 Copayment per visit (any additional services, such as lab, x-ray, and other Diagnostic Services are subject to Deductible and Coinsurance)	**Out-of-Network** BCI pays 70% of Maximum Allowance after Deductible
Post-Mastectomy/Lumpectomy Reconstructive Surgery	**In-Network** BCI pays 85% of Maximum Allowance after Deductible	**Out-of-Network** BCI pays 70% of Maximum Allowance after Deductible
Professional Services (Surgical/Medical)	**In-Network** BCI pays 85% of Maximum Allowance after Deductible	**Out-of-Network** BCI pays 70% of Maximum Allowance after Deductible
Selected Other Therapy Services Includes, but is not limited to: • Radiation Therapy • Chemotherapy • Renal Dialysis	**In-Network** BCI pays 85% of Maximum Allowance after Deductible	**Out-of-Network** BCI pays 70% of Maximum Allowance after Deductible
Skilled Nursing Facility	**In-Network** BCI pays 85% of Maximum Allowance after Deductible	**Out-of-Network** BCI pays 70% of Maximum Allowance after Deductible

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SERVICES BCI COVERS	***AMOUNT OF PAYMENT***	
	up to 30 days per Insured, per Benefit Period	
Transplant Services	**In-Network** BCI pays 85% of Maximum Allowance after Deductible	**Out-of-Network** BCI pays 70% of Maximum Allowance after Deductible
	Lifetime Benefit Limit is $350,000 per Insured	
Wellness/Preventive Care Services For specifically listed services • *Well-Baby and Well-Child Care—routine or scheduled well-baby and well-child examinations, including Rubella and PKU tests.* • *Adult Examinations—annual physical examinations, including pap tests, fecal occult blood tests, PSA tests, cholesterol panel. and CBC and SMAC blood tests* • *Immunizations—Accellular Pertussis, Diphtheria, Hemophilus Influenza B, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pneumococcal (pneumonia), Poliomyelitis (polio), Rubella, Tetanus, Varicella (Chicken Pox) and routine immunizations included in the State of Idaho Vaccine for Children Program, as amended or revised. (Other immunizations may be covered at the discretion of BCI when Medically Necessary. No benefits are provided for travel vaccines.).* For services not specifically listed	**In-Network** Insured pays $20 Copayment per visit Immunizations require No Copayment BCI pays 85% of Maximum Allowance after Deductible	**Out-of-Network** No benefits

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PRESCRIPTION DRUG BENEFITS
Three-Tier Copayment Program

	In-Network	Out-of-Network
Tier 1: Generic Drugs	Insured pays $12 per prescription	
Tier 2: Brand Name Drugs – no Generic available	Insured pays $18 per prescription	Insured pays $25 ***and*** 20% of balance, per prescription
Tier 3: Brand Name Drugs – Generic available	Insured pays $40 + difference between Brand Name and Generic Drug, per prescription	
One (1) Copayment for ***each*** 30-day supply Two (2) Copayments for ***each*** 90-day supply of Maintenance drugs only (1-30 day supply, 1 copayment; 31-90 day supply, 2 copayments) **Note:** Certain prescription drugs have Generic equivalents. If the Insured or Provider requests a Brand Name Drug and a Generic Drug is available, the Insured is responsible for the difference between the price of the Generic Drug and the Brand Name Drug plus any applicable Copayment.		
Diabetes Management	**In-Network**	**Out-of-Network**
Insulin Syringes/Needles Insulin syringes/needles covered if purchased within 30 days of Insulin purchase. (only 1 copayment required)	Insulin subject to above listed pharmacy copays.	Insured pays $25 ***and*** 20% of balance, per purchase
Other Diabetic Supplies Benefits shall be provided for blood sugar diagnostics: • lancets • swabs • test strips	Insured pays $10 per item	
Contraceptives	**In-Network**	**Out-of-Network**
Oral Contraceptives Only • *Only* oral contraceptives are covered for the enrolled employee or employee's enrolled spouse • Prescription birth control drugs *are not* covered for dependent children	Subject to above listed pharmacy copays	Insured pays $25 ***and*** 20% of balance, per purchase

VISION CARE BENEFITS (VSP) **1-800-877-7195**	
	VSP pays up to the amounts listed:
Professional Fees • Eye Exam	$32
Materials—lenses per pair • Single Vision, up to • Bifocal, up to • Trifocal, up to • Lenticular, up to	$32 $60 $72 $100
• Frame, up to	$30
Contact Lenses— per pair (evaluation, materials, and fittings only) • Elective, up to • Medically Necessary, up to	$47 $100
Service Frequency Limitations	Insured may receive one (1) eye exam every twelve (12) months. Insured may receive one (1) pair spectacle lenses or contact lenses every twelve (12) months. Insured may receive one (1) frame every twenty-four (24) months.

INTEGRATED BEHAVIORAL HEALTH PLAN BENEFITS (IBHP)

EAP, mental health & substance abuse benefits are administered by Business Psychology Associates (BPA): See Integrated Behavioral Health Plan Benefits Section for details.

Preauthorization is required before utilizing services and benefits. Call toll-free 24 hours per day, 7 days per week. **1-877-427-2327**. Treasure Valley residents call **343-4180**. Visit **www.bpahealth.com.**

	Pre-Authorized Cost per billable hour In-Network	***Pre-Authorized Cost per billable hour Out-Of-Network***
EAP Benefits	5 visits per person per Benefit Period	No benefit
Maximum Benefit per Benefit Period	200 Hours In-Network & Out-Of-Network combined	
Benefit Period Deductible	$150.00 individual/$300.00 Family	
Facility-based Individual care and services: • Acute in-patient psychiatric • In-patient detox • Partial or day hospitalization • Intensive out-patient programs • Residential programs for substance abuse	$15 copayment **per billable hour,** after deductible	50% coinsurance **per billable hour** of maximum allowance, after deductible
Out-Patient Individual care and services: • Psychiatric evaluation and medication management • Psychological testing & services • Professional counseling • Family & Group counseling	$25 copayment **per billable hour,** after deductible	50% coinsurance **per billable hour/visit** of maximum allowance, after deductible

Business Psychology Associates (BPA) administers these services.
These benefits are not part of the medical benefit plan administered by Blue Cross of Idaho.
All preauthorization requests and inquiries for EAP, mental health and/or substance abuse services need to be directed to BPA at 1-877-427-2327 or 1-208-343-4180.

Attachment A:

NON-EMERGENCY SERVICES REQUIRING PRIOR AUTHORIZATION ANNUAL NOTICE

NOTICE: THE SERVICES LISTED SHOULD BE AUTHORIZED IN ADVANCE IN ORDER TO BE ELIGIBLE FOR BENEFITS UNDER THE TERMS OF THIS POLICY. Failure to obtain Prior Authorization may result in a penalty or these services being noncovered and the Insured's responsibility.

For additional information, please check with your provider, call Customer Service at the telephone number listed on the back of the Enrollee's Identification Card or check our BCI website at www.bcidaho.com.

Surgical Services – Inpatient or Outpatient
- Organ and tissue transplants
- Gallbladder surgery
- Arthroscopic surgery of the knee, hip, shoulder, wrist, or jaw
- Nasal and sinus procedures
- Eyelid surgery
- Spinal surgery
- Hysterectomy
- Gastric reflux procedures
- Plastic and reconstructive surgery
- Surgery for snoring or sleep problems
- Invasive treatment of lower extremity veins (including but not limited to varicose veins)

Other Services
- Inpatient stays that originate from an outpatient service
- Diabetes self management education
- Home intravenous therapy
- Non-emergent ambulance
- Certain prescription drugs (including drugs that cost $500 or more)
- Restorative dental services following accidental injury to sound natural teeth
- Hospice services
- Growth hormone therapy
- Mental health and/or substance abuse services (contact Business Psychology Associates, 1-800-427-2327)

The following services require Prior Authorization when the expected charges exceed three hundred dollars ($300):
- Rental or purchase of Durable Medical Equipment
- Prosthetic Appliances
- Orthotic Devices

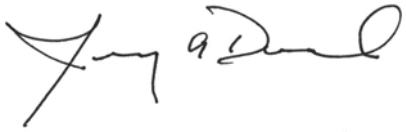
ACCEPTANCE

In consideration of the accepted Blue Cross of Idaho fully insured proposal, and the continuing payment of premiums when due, and subject to all terms of this Policy, Blue Cross of Idaho hereby agrees to provide each enrolled Insured of the Group the benefits of this Policy (Group Policy Number 10040000), beginning on each Insured's Effective Date.

This Policy renews on an annual basis. Premium payments are due on a month-to-month basis. The Group's Policy Date is July 1, 2005 to June 30, 2006.

State of Idaho
Department of Administration
650 West State Street
P.O. Box 83720
Boise, ID 83720-0003

Blue Cross of Idaho
Health Service, Inc.
PO Box 7408
Boise, ID 83707



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Pamela I. Ahrens
Director, Department of Administration

Jerry A. Dworak
Sr. VP & Chief Marketing Officer
June 30, 2005

HOW TO SUBMIT CLAIMS

An Insured must submit a claim to Blue Cross of Idaho (BCI) in order to receive benefits for Covered Services. There are two ways for an Insured to submit a claim:

1. The health care Provider (hospital, doctor, or other facility or specialist) can file the claims for the Insured. Most Providers will submit a claim on an Insured's behalf if the Insured shows them a BCI identification card and asks them to send BCI the claim.

2. The Insured can send BCI the claim.

To File An Insured's Own Claim
If a doctor or hospital prefers that an Insured file the claim, here is the procedure to follow:

1. Ask the doctor or hospital for an itemized billing. The itemized billing should show each service received and its procedure code and its diagnosis code, the date each service was furnished, and the charge for each service. BCI cannot accept billings that only say "Balance Due," "Payment Received" or some similar statement.

2. Obtain a Patient Questionnaire form from the doctor or BCI, and follow the instructions. Use a separate billing and Patient Questionnaire form for each patient.

3. Attach the billing to the Patient Questionnaire and send it to:

   Blue Cross of Idaho Claims Control
   Blue Cross of Idaho
   P.O. Box 7408
   Boise, ID 83707

For assistance with claims or health benefit information, please call BCI Customer Service at 1-208-331-8897 or 1-866-804-2253.

How Blue Cross of Idaho Notifies the Insured
BCI will send the Insured an Explanation of Benefits (EOB) as soon as the claim is processed. The EOB will show all the payments BCI made and to whom the payments were sent. It will also explain any charges BCI did not pay in full. Insureds should keep this EOB for their records.

INPATIENT NOTIFICATION SECTION

This section describes procedures that must be followed in order for Insureds to receive the maximum benefits available for Covered Services. As specified, Non-Emergency Preadmission Notification or Emergency Admission Notification is required for all Inpatient services.

NOTE: Some Inpatient services also require the Provider to obtain Prior Authorization. Please refer to the Prior Authorization Section.

I. Non-emergency Preadmission Notification

Non-Emergency Preadmission Notification is a notification to Blue Cross of Idaho by the Insured and is required for all Inpatient admissions except Covered Services subject to Emergency or Maternity Admission Notification. An Insured must notify BCI of all proposed Inpatient admissions as soon as he or she knows he or she will be admitted as an Inpatient. The notification must be made before any Inpatient admission. Non-Emergency Preadmission Notification informs BCI, or a delegated entity, of the Insured's proposed Inpatient admission to a Licensed General Hospital, Alcohol or Substance Abuse Treatment Facility, Psychiatric Hospital, or any other Facility Provider. This notification alerts Blue Cross of Idaho of the proposed stay. When timely notification of an Inpatient admission is provided by the Insured to BCI, payment of benefits is subject to the specific benefit levels, limitations, exclusions and other provisions of this Policy.

If an Insured does not notify Blue Cross of Idaho regarding the proposed stay, the Insured may incur a penalty.

For Non-Emergency Preadmission Notification call BCI at 1-208-331-8897 or 1-866-804-2253.

II. Emergency or Maternity Admission Notification

When an Emergency Admission occurs for Emergency Medical Conditions, an unscheduled cesarean section delivery, or maternity delivery services, and notification cannot be completed prior to admission due to the Insured's condition, the Insured, or his or her representative, must notify BCI within twenty-four (24) hours of the admission. If the admission is on a weekend or legal holiday, BCI must be notified by the end of the next working day after the admission. If the Emergency Medical Condition, unscheduled cesarean section delivery, or maternity delivery services, renders it medically impossible for the Insured to provide such notice, the Insured must immediately notify BCI of the admission when it is no longer medically impossible to do so.

This notification alerts BCI to the emergency stay.

If an Insured does not notify BCI of the Emergency or Maternity Admission, the Insured may incur a penalty.

III. Penalty for Improper Notification

If Non-Emergency Preadmission Notification or Emergency or Maternity Admission Notification is not provided by the Insured according to the terms of this Policy, then eligible expenses for the Covered Services will be reduced by fifty percent (50%) or five hundred dollars ($500) per admission, whichever is less. This reduction is not a covered expense. Further this reduction will not apply toward the Insured's Out-of-pocket Limit. Benefits for the balance will be paid as specified in the applicable benefits section(s) of this Policy.

IV. Continued Stay Review

BCI will contact the hospital utilization review department and/or the attending Physician regarding the Insured's proposed discharge. If the Insured will not be discharged as originally proposed, BCI will evaluate the Medical Necessity of the continued stay and approve or disapprove benefits for the proposed course of Inpatient treatment. Payment of benefits is subject to the specific benefit levels, limitations, exclusions and other provisions of this Policy.

V. Discharge Planning

BCI will provide information about benefits for various post-discharge courses of treatment.

PRIOR AUTHORIZATION SECTION

NOTICE: ***The Medical Necessity of Covered Services listed below should be determined to be eligible for benefits under the terms of this Policy. If Prior Authorization has not been obtained to determine Medical Necessity, services may be subject to denial. Any dispute involved in this decision to deny must be resolved by use of the Blue Cross of Idaho appeal process as outlined in the General Provisions Section.***

If Non-Medically Necessary services are performed by Contracting Providers, without the Prior Authorization by Blue Cross of Idaho, and benefits are denied, the cost of said services are not the financial responsibility of the Insured.

The Insured is financially responsible for Non-Medically Necessary services provided by a Noncontracting Provider.

Prior Authorization is a request by the Insured's Contracting Provider to BCI, or delegated entity, for authorization of an Insured's proposed treatment. BCI may review medical records, test results and other sources of information to ensure that it is a Covered Service and make a determination as to Medical Necessity or alternative treatments.

The Insured is responsible for obtaining Prior Authorization when seeking treatment from a Noncontracting Provider.

When a Contracting Provider or Insured has obtained Prior Authorization for Outpatient Services, but the services are rendered on an Inpatient basis without further notification to BCI, the Maximum Allowance will be reduced by fifty percent (50%) or five hundred dollars ($500), whichever is less.

Please refer to Attachment A of the Benefits Outline, check the BCI website at www.bcidaho.com, or call Customer Service at the telephone number listed on the back of the Insured's Identification Card to determine if the Insured's proposed services require Prior Authorization. To request Prior Authorization, the Contracting Provider must notify BCI of the Insured's intent to receive services that require Prior Authorization.

The Insured is responsible for notifying BCI if the proposed treatment will be provided by a Noncontracting Provider.

The notification may be completed by telephone call or in writing and must include the information necessary to establish that the proposed services are Covered Services under the Insured's Policy and Medically Necessary. BCI will respond to a request for Prior Authorization received from either the Provider or the Insured within two (2) business days of the receipt of the medical information necessary to make a determination.

COMPREHENSIVE MAJOR MEDICAL BENEFITS SECTION

This section specifies the benefits an Insured is entitled to receive for the Covered Services described, subject to the other provisions of this Policy.

Note: It is important to remember that when the term 'Contracting' is designated in front of the specific Covered Provider, all Major Medical Covered Services must be furnished by Contracting Providers. There are no benefits when Covered Services are provided by Noncontracting Providers in the state of Idaho.

I. Benefit Period

The Benefit Period is the specified period of time during which an Insured's benefits for incurred Covered Services accumulate toward annual benefit limits, Deductible amounts and Out-of-pocket Limits. The Benefit Period consists of the contract year from July 1 to June 30 of the following year unless otherwise noted. If the Insured's Effective Date is after the Policy Date, the initial Benefit Period for that Insured may be less than twelve (12) months.

The Benefit Period for Hospice Home Care Covered Services is a continuous six (6) month period that begins when a Hospice Plan of Treatment is approved by Blue Cross of Idaho (BCI). The Insured may apply to BCI for an extension of the Hospice Home Care Benefit Period if Hospice benefits have not otherwise been exhausted.

II. Deductible

A. Individual

The Individual Deductible is shown in the Benefits Outline.

B. Family

The Family Deductible is shown in the Benefits Outline.

III. Out-of-Pocket Limit

The Out-of-pocket Limit is shown in the Benefits Outline. Eligible Out-of-pocket expenses include only the Insured's Deductible and Coinsurance for eligible Covered Services. If an Insured is admitted as an Inpatient at the end of a Benefit Period and the hospitalization continues uninterrupted into the succeeding Benefit Period, all eligible Out-of-pocket expenses incurred for Inpatient Hospital Services are considered part of the Benefit Period in which the date of admission occurred. Out-of-pocket expenses associated with the following are not included in the Out-of-pocket Limit:

A. Amounts that exceed the Maximum Allowance.

B. In-Network Copayments.

C. Amounts that exceed benefit limits.

D. Dental Covered Services, except Dental Services Related to Accidental Injury.

E. Vision care Covered Services.

F. Prescription Drug Covered Services.

G. Noncovered services or supplies.

H. Mental health and substance abuse services.

IV. Aggregate Deductible and Out-of-Pocket Maximums

Only in the instance where both the Enrollee and the Enrollee's spouse are employees of the Group and each Eligible Employee has separate coverage under the same Health Benefit Plan, the Deductible and Out-of-pocket amounts accrued under one Insured's enrollment shall also be credited toward the family aggregate Deductible and Out-of-pocket amounts of the other Insured's enrollment, as applicable.

V. Covered Providers

Note: It is important to remember that when the term 'Contracting' is designated in front of the specific Covered Provider, all Major Medical Covered Services must be furnished by Contracting Providers. There are no benefits when Covered Services are provided by Noncontracting Providers in the state of Idaho.

The following are Covered Providers under this section:

- Ambulance Transportation Service
- Ambulatory Surgical Facility (Surgery Center)
- Certified Nurse-Midwife
- Certified Registered Nurse Anesthetist
- Certified Speech Therapist
- Clinical Nurse Specialist
- Chiropractic Physician
- Contracting Electroencephalogram (EEG) Provider
- Contracting Hospice
- Contracting Licensed Rehabilitation Hospital
- Contracting Lithotripsy Provider
- Dentist/Denturist
- Diagnostic Imaging Provider
- Durable Medical Equipment Supplier
- Freestanding Diabetes Facility
- Freestanding Dialysis Facility
- Home Health Agency
- Home Intravenous Therapy Company
- Independent Laboratory
- Licensed General Hospital
- Licensed Occupational Therapist
- Licensed Physical Therapist
- Nurse Practitioner
- Optometrist/Optician
- Physician
- Physician Assistant
- Podiatrist
- Prosthetic and Orthotic Supplier
- Skilled Nursing Facility

VI. Covered Services

Note: In order to receive benefits, some Covered Services require Prior Authorization. Please review the Prior Authorization Section for more specific details.

Only the following are eligible Major Medical expenses:

A. Hospital Services

1. **Inpatient Hospital Services**

a) **Room and Board and General Nursing Service**

Room and board, special diets, the services of a dietician, and general nursing service when an Insured is an Inpatient in a Licensed General Hospital is covered as follows:

(1) A room with two (2) or more beds is covered. If a private room is used, the benefit provided in this section for a room with two (2) or more beds will be applied toward the charge for the private room. Any difference between the charges is a noncovered expense under this Policy and is the sole responsibility of the Insured.

(2) If isolation of the Insured is: (a) required by the law of a political jurisdiction, or (b) required to prevent contamination of either the Insured or another patient by the Insured, then payment for approved private room isolation charges shall be in place of the benefits for the daily room charge stated in paragraph one (1).

(3) Benefits for a bed in a Special Care Unit shall be in place of the benefits for the daily room charge stated in paragraph one (1).

(4) A bed in a nursery unit is covered.

b) **Ancillary Services**

Licensed General Hospital services and supplies including:

(1) Use of operating, delivery, cast, and treatment rooms and equipment.

(2) Prescribed drugs administered while the Insured is an Inpatient.

(3) Administration and processing of whole blood and blood products when the whole blood or blood products are actually used in a transfusion for an Insured; whole blood or blood plasma that is not donated on behalf of the Insured or replaced through contributions on behalf of the Insured.

(4) Anesthesia, anesthesia supplies and services rendered by the Licensed General Hospital as a regular hospital service and billed by the same hospital in conjunction with a procedure that is a Covered Service.

(5) All medical and surgical dressings, supplies, casts, and splints that have been ordered by a Physician and furnished by a Licensed General Hospital.

(6) Oxygen and administration of oxygen.

(7) Patient convenience items essential for the maintenance of hygiene provided by a Licensed General Hospital as a regular hospital service in connection with a covered hospital stay. Patient convenience items include, but are not limited to, an admission kit, disposable washbasin, bedpan or urinal, shampoo, toothpaste, toothbrush, and deodorant.

(8) Diagnostic Services and Therapy Services.

If Diagnostic Services or Therapy Services furnished through a Licensed General Hospital are provided by a Physician under contract with the same hospital to perform such services and the Physician bills separately, then the Physician's services are a Covered Service.

2. **Outpatient Hospital Services**

a) **Emergency Care**

Licensed General Hospital services and supplies for the treatment of Accidental Injuries, Diseases or Illnesses.

b) **Surgery**

Licensed General Hospital or Ambulatory Surgical Facility services and supplies including removal of sutures, anesthesia, anesthesia supplies and services. The furnished supplies and services must be in conjunction with a Covered Service rendered by an employee of one (1) of the above facilities who is not the surgeon or surgical assistant.

c) **Therapy Services**

3. **Special Services**

a) **Preadmission Testing**

Tests and studies required with the Insured's admission and accepted or rendered by a Licensed General Hospital on an Outpatient basis prior to a scheduled admission as an Inpatient, if the services would have been available to an Inpatient of a Licensed General Hospital. Preadmission Testing does not include tests or studies performed to establish a diagnosis.

Preadmission Testing benefits are limited to Inpatient admissions for Surgery. Preadmission Testing must be conducted within seven (7) days prior to an Insured's Inpatient admission.

Preadmission Testing is a Covered Service only if the services are not repeated when the Insured is admitted to the Licensed General Hospital as an Inpatient, and

only if the tests and charges are included in the Inpatient medical records.

No benefits for Preadmission Testing are provided if the Insured cancels or postpones the admission to the Licensed General Hospital as an Inpatient. If the Licensed General Hospital or Physician cancels or postpones the admission then benefits are provided.

b) Hospital benefits may be provided for dental extractions, or other dental procedures if certified by a Physician that a non-dental medical condition requires hospitalization to safeguard the health of the Insured. Non-dental conditions that may receive hospital benefits are:
   (1) Brittle diabetes.
   (2) History of a life-endangering heart condition.
   (3) History of uncontrollable bleeding.
   (4) Severe bronchial asthma.
   (5) Children under ten (10) years of age who require general anesthetic.
   (6) Other non-dental life-endangering conditions that require hospitalization, subject to approval by BCI.

B. Skilled Nursing Facility

Benefits provided to an Inpatient of a Licensed General Hospital are also provided for services and supplies customarily rendered to an Inpatient of a Skilled Nursing Facility. Benefits are provided up to the maximum stay (the number of days for a maximum stay is shown in the Benefits Outline). If the Insured is receiving care at a Skilled Nursing Facility at the end of a Benefit Period, this annual maximum stay benefit shall not renew the following Benefit Period until the Insured is discharged. However, no benefits are provided when the care received consists primarily of:

1. Room and board, routine nursing care, training, supervisory, or Custodial Care.
2. Care for senile deterioration, mental deficiency or mental retardation.
3. Care for Mental or Nervous Conditions, Alcoholism or Substance Abuse or Addiction.
4. Maintenance Physical Therapy, hydrotherapy, Speech Therapy, or Occupational Therapy.

When Medicare is primary, the number of days as shown in the Benefit Outline is in addition to the Skilled Nursing Facility days paid in full by Medicare.

C. Ambulance Transportation Service

Ambulance Transportation Service is covered for Medically Necessary transportation of an Insured within the local community by Ambulance under the following conditions:

1. From an Insured's home or scene of Accidental Injury or Emergency Medical Condition to a Licensed General Hospital.
2. Between Licensed General Hospitals.
3. Between a Licensed General Hospital and a Skilled Nursing Facility.
4. From a Licensed General Hospital to the Insured's home.
5. From a Skilled Nursing Facility to the Insured's home.

For purposes of C.1., 2. and 3. above, if there is no facility in the local community that can provide Covered Services appropriate to the Insured's condition, then Ambulance Transportation Service means transportation to the closest facility that can provide the necessary service.

For purposes of this section, Ambulance means a specially designed and equipped vehicle used only for transporting the sick and injured.

D. Mental Health and Substance Abuse Services

Benefits for mental health and substance abuse services are provided by an independent Service Benefits Manager. See Integrated Behavioral Health Plan Benefits Section.

E. Maternity Services

The benefits provided for Licensed General Hospital Services and Surgical/Medical Services are also provided for the maternity services listed below when rendered by a Licensed General Hospital or Physician to the Enrollee or the Enrollee's spouse (if an Insured). Nursery care of a newborn infant is not a maternity service and is covered under Inpatient Hospital Services.

Benefits for any hospital stay in connection with childbirth for the mother or newborn child will include forty-eight (48) hours following a vaginal delivery and ninety-six (96) hours following a cesarean section delivery. Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) or ninety-six (96) hours. For stays in excess of forty-eight (48) or ninety-six (96) hours, additional benefits may be available under the terms of Item IV., Continued Stay Review in the Inpatient Notification Section. Tests to determine pregnancy are covered. Diagnostic x-ray and laboratory services related to pregnancy, childbirth, or miscarriage are covered.

No benefits are provided for any Normal Pregnancy or Involuntary Complications of Pregnancy for enrolled Eligible Dependent children. However, tests to determine pregnancy are covered. All other diagnostic x-ray and laboratory services related to pregnancy, childbirth, or miscarriage are not covered for dependent children.

1. **Normal Pregnancy**
   Normal Pregnancy includes all conditions arising from pregnancy or delivery, including any condition usually associated with the management of a difficult pregnancy that is not defined below as an Involuntary Complication of Pregnancy.
2. **Involuntary Complications of Pregnancy**
   a) Involuntary Complications of Pregnancy include, but are not limited to:
      (1) Cesarean section delivery, ectopic pregnancy that is terminated, spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible (miscarriage), puerperal infection, and eclampsia.
      (2) Conditions requiring Inpatient confinement (when the pregnancy is not terminated), the diagnoses of which are distinct from pregnancy but are adversely affected or are caused by pregnancy. These conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but do not include false labor, occasional spotting, Physician-prescribed bed rest during pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
      (3) A life-endangering condition. Benefits for termination of pregnancy are provided only if the Insured suffers a life-endangering condition and the Insured is eligible for maternity services.

F. Transplant Services

For Covered Services rendered, BCI will pay or otherwise satisfy a percentage of the Maximum Allowance up to the Lifetime Benefit Limit as shown in the Benefits Outline.

1. **Transplants or Autotransplants**
   Transplants or Autotransplants of arteries, veins, blood, ear bones, cartilage, muscles, skin and tendons; heart valves, regardless of their source; implanting of artificial or mechanical pacemakers; and Autotransplanting of teeth or tooth buds.
   a) The applicable benefits provided for hospital and Surgical/Medical Services are also provided only for a recipient of Medically Necessary Transplant services.
   b) No benefits are available for services, expenses, or other obligations of or for a donor (even if the donor is an Insured).
2. **Transplants**
   Transplants of corneas, kidneys, bone marrow, livers, hearts, lungs, heart/lung and pancreas/kidney combinations.
   a) The applicable benefits provided for Hospital and Surgical/Medical Services are

also provided for a recipient of Medically Necessary Transplant services.

b) Benefits for a recipient of a bone marrow, liver, heart, lung, heart/lung or pancreas/kidney combination Transplant(s) are subject to the following conditions:
   (1) The Transplant must be preauthorized by BCI.
   (2) The recipient must have the Transplant performed at an appropriate Recognized Transplant Center. If the recipient is eligible for Medicare, the recipient must have the Transplant performed at a Recognized Transplant Center that is approved by the Medicare program for the requested Transplant Covered Services.

c) If the recipient is eligible to receive benefits for these transplant services, Organ Procurement charges are paid for the donor (even if the donor is not an Insured). Benefits for the donor will be charged to the recipient's coverage.

3. **Exclusions and Limitations**

In addition to any other exclusions and limitations of this Policy, the following exclusions and limitations apply to Transplant services. No benefits are available under this Policy for the following:

a) Transplants of brain tissue or brain membrane, islet tissue, pancreas, intestine, pituitary and adrenal glands, hair Transplants, or any other Transplant not specifically named as a Covered Service in this section; or for Artificial Organs including but not limited to, artificial hearts or pancreases.
b) Any eligible expenses of a donor related to donating or transplanting an organ or tissue unless the recipient is an Insured who is eligible to receive benefits for Transplant services.
c) The cost of a human organ or tissue that is sold rather than donated to the recipient.
d) Transportation costs including but not limited to, Ambulance Transportation Service or air service for the donor, or to transport a donated organ or tissue.
e) Living expenses for the recipient, donor or family members.
f) Costs covered or funded by governmental, foundation or charitable grants or programs; or Physician fees or other charges, if no charge is generally made in the absence of insurance coverage.
g) Any complication to the donor arising from a donor's Transplant Surgery is not a covered benefit under the Insured Transplant recipient's Policy. If the donor is a BCI Insured, eligible to receive benefits for Covered Services, benefits for medical complications to the donor arising from Transplant Surgery will be allowed under the donor's policy.
h) Costs related to the search for a suitable donor.

G. Surgical/Medical Services

1. **Surgical Services**

a) **Surgery**—Surgery performed by a Physician or other Professional Provider.
b) **Multiple Surgical Procedures**—benefits for multiple surgical procedures performed during the same operative session by one (1) or more Physicians or other Professional Providers are calculated based upon BCI's Maximum Allowance and payment guidelines.
c) **Surgical Supplies**—when a Physician or other Professional Provider performs covered Surgery in the office, benefits are available for a sterile suture or Surgery tray normally required for minor surgical procedures.
d) **Surgical Assistant**—Medically Necessary services rendered by a Physician or other appropriately qualified surgical assistant who actively assists the operating surgeon in the performance of covered Surgery where an assistant is required. The percentage of the Maximum Allowance that is used as the actual Maximum Allowance to calculate the amount of payment under this section for Covered Services rendered by a surgical assistant is 20% for a Physician assistant and 10% for other appropriately qualified surgical assistants.
e) **Anesthesia**—in conjunction with a covered procedure, the administration of anesthesia ordered by the attending Physician and rendered by a Physician or other Professional Provider. The use of Hypnosis as anesthesia is not a Covered Service. General anesthesia administered by the surgeon or assistant surgeon is not a

Covered Service.

f) **Second and Third Surgical Opinion**—

(1) Services consist of a Physician's consultative opinion to verify the need for elective Surgery as first recommended by another Physician.

(2) Specifications:

(a) Elective Surgery is covered Surgery that may be deferred and is not an emergency.

(b) Use of a second consultant is at the Insured's option.

(c) If the first recommendation for elective Surgery conflicts with the second consultant's opinion, then a third consultant's opinion is a Covered Service.

(d) The third consultant must be a Physician other than the Physician who first recommended elective Surgery or the Physician who was the second consultant.

2. **Inpatient Medical Services**

Inpatient medical services rendered by a Physician or other Professional Provider to an Insured, who is receiving Covered Services in a Licensed General Hospital or Skilled Nursing Facility.

Inpatient medical services also include consultation services when rendered to an Insured as an Inpatient of a Licensed General Hospital by another Physician at the request of the attending Physician. Consultation services do not include staff consultations that are required by Licensed General Hospital rules and regulations.

3. **Outpatient Medical Services**

The following Outpatient medical services rendered by a Physician or other Professional Provider to an Insured who is an Outpatient, provided such services are not related to pregnancy, Chiropractic Care, Mental or Nervous Conditions, Alcoholism, Substance Abuse or Addiction, or Pain Rehabilitation, except as specified elsewhere in this section:

a) **Emergency Care**—medical care for the treatment of an Accidental Injury, Disease, condition or Illness.

b) **Special Therapy Services**—deep radiation therapy or chemotherapy for a malignancy when such therapy is performed in the Physician's office.

c) **Home and Other Outpatient Services**—medical care for the diagnosis or treatment of an Accidental Injury, Disease, condition or Illness.

d) **Wellness/Preventive Care Services**

Benefits are provided for:

(1) Well-Baby and Well-Child Care—routine or scheduled well-baby and well-child examinations, including Rubella and PKU tests.

(2) Adult Examinations—annual physical examinations, including pap tests, fecal occult blood tests, PSA tests, cholesterol panel, and CBC and SMAC blood tests.

(3) Immunizations—see Benefits Outline for complete list.:

Benefits for In-Network Covered Services are shown in the Benefits Outline. No benefits are provided for Out-of-Network Covered Services.

e) **Physician Office Visit**—Physician office medical visits and consultations, including visits for wellness and preventive health services. The office visit does not include visits for the treatment or diagnosis of Mental or Nervous Conditions or any additional services provided in the Physician's office, such as lab, x-ray, and other diagnostic services. Benefits for In-Network and Out-of-Network Covered Services are shown in the Benefits Outline.

H. Diagnostic Services

Diagnostic Services are covered provided such services are not related to Chiropractic Care. Diagnostic Services include mammograms. Tests to determine pregnancy and Pap tests are covered regardless of results. Benefits are provided for Medically Necessary genetic testing and counseling of a pregnant Insured eligible for maternity care.

I. Therapy Services

1. **Radiation Therapy**
2. **Chemotherapy**
3. **Renal Dialysis**
4. **Physical Therapy**

a) Payment is limited to Physical Therapy Services related to developmental and rehabilitative care, with reasonable expectation that the services will produce significant improvement in the Insured's condition in a reasonable period of time. Physical Therapy Services are covered when performed by:
   (1) A Physician.
   (2) A Licensed Physical Therapist, provided the Covered Services are directly related to a written treatment regimen prepared by the Therapist.
   (3) A Podiatrist.

b) No benefits are provided for:
   (1) The following Physical Therapy Services when the specialized skills of a Licensed Physical Therapist are not required:
      (a) Repetitive exercise(s) to improve gait and maintain strength and endurance.
      (b) Range of motion and passive exercises that are not related to restoration of a specific loss of function but are useful in maintaining range of motion in paralyzed extremities.
      (c) Assistance in walking, such as that provided in support for feeble or unstable patients.
   (2) Facility-related charges for Outpatient Physical Therapy Services, health club dues or charges, or Physical Therapy Services provided in a health club, fitness facility, or similar setting.
   (3) General exercise programs, even when recommended by a Physician or a Chiropractic Physician, and even when provided by a Licensed Physical Therapist.

5. **Respiratory Therapy**
6. **Occupational Therapy**

a) Payment is limited to Occupational Therapy Services related to developmental and rehabilitative care, with reasonable expectation that the services will produce significant improvement in the Insured's condition in a reasonable period of time. Occupational Therapy Services are covered when performed by:
   (1) A Physician.
   (2) A Licensed Occupational Therapist, provided the Covered Services are directly related to a written treatment regimen prepared by an Occupational Therapist and approved by a Physician.

b) No benefits are provided for:
   (1) Facility-related charges for Outpatient Occupational Therapy Services, health club dues or charges, or Occupational Therapy Services provided in a health club, fitness facility, or similar setting.
   (2) General exercise programs, even when recommended by a Physician or a Chiropractic Physician, and even when provided by a Licensed Occupational Therapist.

7. **Speech Therapy**

Benefits are limited to Speech Therapy Services related to developmental and rehabilitative care, with reasonable expectation that the services will produce significant improvement in the Insured's condition in a reasonable period of time. Speech Therapy Services are covered when performed by either of the following:

a) A Physician.
b) A Certified Speech Therapist, provided the services are directly related to a written treatment regimen designed by the Therapist.

8. **Enterostomal Therapy**
9. **Growth Hormone Therapy**

Benefits for this Therapy are only available as preauthorized and

approved by BCI when Medically Necessary.

10. **Home Intravenous Therapy**
    Benefits for this Therapy are only available as preauthorized and approved by BCI when Medically Necessary.

J. Home Health Skilled Nursing Care Services

Professional nursing services provided to a Homebound Insured that can only be rendered by a licensed registered nurse (R.N.) or a licensed practical nurse (L.P.N.), provided such nurse does not ordinarily reside in the Insured's household or is not related to the Insured by blood or marriage. The services must be Medically Necessary and preauthorized by BCI and the patient's Physician and must not constitute Custodial Care. Services must be provided by a Medicare certified Home Health Agency and limited to intermittent Skilled Nursing Care. The patient's Physician must review the care at least every thirty (30) days. No benefits are provided during any period of time in which the Insured is receiving Hospice Covered Services.

The percentage of the Maximum Allowance that BCI will pay or otherwise satisfy for In-Network and Out-of-Network Covered Home Health Skilled Nursing Care Services and the benefit limit for such services are shown in the Benefits Outline.

K. Hospice Home Care Services

Benefits provided under other sections of this Policy are available except as modified by this section. Benefits are provided only for covered Hospice Services included in a Hospice Plan of Treatment that has been preauthorized by BCI.

For In-Network Hospice Covered Services rendered by a Contracting Hospice, BCI will pay or otherwise satisfy a percentage of the Maximum Allowance up to the Lifetime Benefit Limit as shown in the Benefits Outline. Deductibles do not apply to expenses for services and supplies provided as part of a Hospice Plan of Treatment preauthorized by BCI.

No benefits are provided for Out-of-Network Hospice Covered Services.

The following benefits are provided only for services and supplies furnished by a Contracting Hospice:

1. Hospice Nursing Care visits are limited to two (2) visits in any day except during a period of Continuous Crisis Care or Respite Care. A visit is limited to no more than two (2) hours of continuous Skilled Nursing Care or four (4) hours of continuous Home Health Aide services.
2. Medical care rendered by a Contracting Hospice Physician.
3. Hospice Physical Therapy, Speech Therapy, and Respiratory Therapy provided by certified or registered therapists.
4. Medical social services, psychological social assessment, and counseling of an Insured as part of a Hospice Plan of Treatment provided by a social worker with a Master of Social Work (M.S.W.) degree. Benefits are limited to two (2) visits.
5. Individual and group counseling services related to coping with the Insured's condition, for immediate family members and the Primary Care Giver. The total benefit for such counseling services is limited to three (3) hours.
6. Initial and follow-up dietary counseling sessions provided by a certified dietician. This benefit is limited to three (3) dietary counseling sessions.
7. Continuous Crisis Care limited to two (2) occurrences of no more than four (4) days each within a three (3) month period. To qualify for Continuous Crisis Care, at least 50% (but in no case less than eight (8) hours) of the total number of continuous hours of care in any day must require Skilled Nursing Care. As determined by the Insured's condition, Home Health Aide care may be used to augment the Skilled Nursing Care.
8. Medical and surgical supplies, Durable Medical Equipment, and oxygen and its administration.
9. Respite Care limited to five (5) days during a three (3) month period.
10. **Conditions**
    An Insured must specifically request Hospice benefits and must meet the following conditions to be eligible:

a) The attending or primary Physician must certify that the Insured is a terminally ill patient with a life expectancy of six (6) months or less.
b) The Insured must live within the Contracting Hospice's local geographical area.
c) The Insured must be formally accepted by the Contracting Hospice.
d) The Insured must have a designated volunteer Primary Care Giver at all times.
e) Services and supplies must be prescribed by the attending Physician and included in a Hospice Plan of Treatment approved in advance by BCI. The Hospice must notify BCI within one (1) working day of any change in the Insured's condition or Plan of Treatment that may affect the Insured's eligibility for Hospice Benefits.
f) Palliative care (which controls pain and relieves symptoms but does not provide a cure) must be appropriate to the Insured's Illness.

11. **Exclusions and Limitations**

No benefits are provided for:

a) Covered Hospice Services not included in a Hospice Plan of Treatment and not provided or arranged and billed through a Contracting Hospice.
b) Continuous Skilled Nursing Care except as specifically provided as a part of Respite Care or Continuous Crisis Care.
c) Hospice benefits provided during any period of time in which an Insured is receiving Home Health Skilled Nursing Care benefits.

L. Chiropractic Care Services

Services rendered, referred, or prescribed by a Chiropractic Physician licensed by the state where services are rendered. For BCI to provide benefits, the individual must be practicing within the scope of license.

The percentage of the Maximum Allowance that BCI will pay or otherwise satisfy for In-Network and Out-of-Network Covered Chiropractic Care Services and the benefit limit for such services are shown in the Benefits Outline.

M. Durable Medical Equipment

The lesser of the Maximum Allowance or billed charge for rental, (but not to exceed the lesser of the Maximum Allowance or billed charge for the total purchase price) or, at the option of BCI, the purchase of Medically Necessary Durable Medical Equipment required for therapeutic use. The Durable Medical Equipment must be prescribed by an attending Physician or other Professional Provider within the scope of license. No benefits are available for the replacement of any item of Durable Medical Equipment that has been used by an Insured for less than five (5) years (whether or not the item being replaced was covered under this Policy). Benefits shall not exceed the cost of the standard, most economical Durable Medical Equipment that is consistent, according to generally accepted medical treatment practices, with the Insured's condition. If the Insured and his or her Provider have chosen a more expensive treatment than is determined to be the standard and most economical by BCI, the excess charge is solely the responsibility of the Insured. Equipment items considered to be common household items are not covered.

N. Prosthetic Appliances

The purchase, fitting, necessary adjustment, repair, and replacement of Prosthetic Appliances including post-mastectomy prostheses.

Benefits for Prosthetic Appliances are subject to the following limitations:

1. The Prosthetic Appliance must be approved by BCI before the Insured purchases it.
2. Benefits shall not exceed the cost of the standard, most economical Prosthetic Appliance that is consistent, according to generally accepted medical treatment practices, with the Insured's condition. If the Insured and his or her Provider have chosen a more expensive treatment than is determined to be the standard and most economical by BCI, the excess charge is solely the responsibility of the Insured.
3. No benefits are provided for dental appliances or major Artificial Organs, including but not limited to, artificial hearts and pancreases.
4. Following cataract Surgery, benefits for a required contact lens or a pair of eyeglasses are limited to the first contact lens or pair of eyeglasses, which must be purchased within ninety

(90) days.

5. No benefits are provided for the rental or purchase of any synthesized, artificial speech or communications output device or system or any similar device, appliance or computer system designed to provide speech output or to aid an inoperative or unintelligible voice, except for voice boxes to replace all or part of a surgically removed larynx.

O. Orthotic Devices

Orthotic Devices include but are not limited to, Medically Necessary braces, back or special surgical corsets, splints for extremities, and trusses, when prescribed by a Physician, Chiropractic Physician, Podiatrist, Contracting Licensed Physical Therapist or Contracting Licensed Occupational Therapist. Arch supports, other foot support devices, orthopedic shoes, and garter belts are not considered Orthotic Devices. Benefits shall not exceed the cost of the standard, most economical Orthotic device that is consistent, according to generally accepted medical treatment practices, with the Insured's condition.

P. Dental Services Related to Accidental Injury

Dental services which are rendered by a Physician or Dentist and required as a result of Accidental Injury to the jaw, sound natural teeth, mouth, or face. Such services are covered only for the twelve (12) month period immediately following the date of injury providing the Policy remains in effect during the twelve (12) month period. Injuries as a result of chewing or biting and Temporomandibular Joint (TMJ) Disorder are not considered accidental injuries. No benefits are available under this section for Orthodontia or Orthognathic services.

Benefits are provided for repair of damage to natural teeth, lips, gums, and other portions of the mouth, including fractures of the maxilla or mandible. Repair or replacement of damaged dentures, bridges, or other dental appliances is not covered, unless the appliance must be modified or replaced due to Accidental Injury to natural teeth which are abutting the bridge or denture.

Benefits for dental services under this provision shall be secondary to dental benefits available to an Insured under another benefit section of this Policy or available under a dental policy of insurance, contract, or underwriting plan that is separate and distinct from this Policy.

Q. Inpatient Physical Rehabilitation Only

Benefits are provided for Inpatient Physical Rehabilitation subject to the following:

1. Admission for Inpatient Physical Rehabilitation must occur within one hundred twenty (120) days of discharge from an Acute Care Licensed General Hospital.
2. Continuation of benefits is contingent upon approval by BCI of a Physical Rehabilitation Plan of Treatment and documented evidence of patient progress submitted to BCI at least twice each month.

For In-Network Covered Services rendered by a Contracting Licensed General Hospital or a Contracting Licensed Rehabilitation Hospital, BCI will pay or otherwise satisfy a percentage of the Maximum Allowance up to the Lifetime Benefit Limit as shown in the Benefits Outline.

No benefits are provided for Out-of-Network Inpatient Physical Rehabilitation Care Covered Services.

R. Outpatient Diabetes Education

For In-Network Services, Outpatient Diabetes Education is provided for Insureds who are either newly diagnosed with diabetes or have had a recent complication of diabetes. Outpatient Diabetes Education includes instruction in the basic skills of diabetes management through books/educational material as well as an individual or group consultation with a Certified Diabetes Educator, nurse, or dietitian.

Coverage for Outpatient Diabetes Education is contingent upon:

1. Pre-approval by BCI—approved programs are hospital-based and meet the standards of the American Diabetes Association; or are supervised by a certified diabetes educator or by a nurse educator with documented credentials.

2. Referral by a Physician.
3. The programs providing written communication back to the referring Physician.
4. Completion of the program, after which program benefits are provided.

For In-Network Services, BCI will pay or otherwise satisfy a percentage of the Maximum Allowance up to the benefit limit as shown in the Benefits Outline.

No benefits are provided for Out-of-Network Outpatient Diabetes Education Covered Services.

S. Outpatient Rehabilitation Therapy Services

For Outpatient Rehabilitation Therapy Services consisting of Outpatient Physical Therapy, Outpatient Speech Therapy, and Outpatient Occupational Therapy Covered Services rendered by a Covered Provider, BCI will pay or otherwise satisfy a percentage of the Maximum Allowance as shown in the Benefits Outline.

Benefits for all Outpatient Rehabilitation Therapy Covered Services combined per Insured, per Benefit Period are shown in the Benefits Outline. If Outpatient Rehabilitation Therapy Covered Services are provided under any other Benefit Section of this Policy, the amount paid under that Benefit Section shall also apply to this benefit limit.

T. Preventive Screening Mammogram Services

Benefits are available for an annual Preventive Screening Mammogram for the detection of breast cancer in its early stages. Preventive Screening Mammograms are x-rays of the breast(s) taken to check for breast cancer in the absence of signs or symptoms.

Benefits for In-Network and Out-of-Network Covered Services are shown in the Benefits Outline.

U. Post-Mastectomy/Lumpectomy Reconstructive Surgery

Reconstructive Surgery in connection with a Disease related mastectomy/lumpectomy, including:
1. Reconstruction of the breast on which the mastectomy/lumpectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy/lumpectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the Insured.

VII. Additional Amount of Payment Provisions

Any amounts remaining unpaid for Covered Services under any other benefit section of this Policy are not eligible for payment under this Comprehensive Major Medical Benefits section. Except as specified elsewhere in this Policy, BCI will provide the following benefits for Covered Services after an Insured has satisfied his or her individual Deductible or, if applicable, the family Deductible has been satisfied:

A. For In-Network Services: Unless stated otherwise, for Major Medical Covered Services rendered in the state of Idaho, BCI will pay or otherwise satisfy a percentage of the Maximum Allowance (shown in the Benefits Outline) if the Covered Services were rendered by any of the Providers listed in this section under item V. Covered Providers. Covered Providers not listed in item V. of this section may be paid at different rates and/or have different benefit limitations. Please refer to the applicable section of the Benefits Outline under "SERVICES BCI COVERS."

For Out-of-Network Services: Unless stated otherwise, for Major Medical Covered Services rendered in the state of Idaho, BCI will pay or otherwise satisfy a percentage of the Maximum Allowance (shown in the Benefits Outline) if the Covered Services were rendered by any of the Providers listed in this section under item V. Covered Providers. Covered Providers not listed in item V. of this section may be paid at different rates and/or have different benefit limitations. Please refer to the applicable section of the Benefits Outline under "SERVICES BCI COVERS."

B. For Major Medical Covered Services furnished by a Covered Provider outside the state of Idaho, Blue Cross of Idaho shall provide the benefit payment levels specified in this section according to the following:
1. If the Provider has a PPO agreement for claims payment with the Blue Cross and/or Blue

Shield plan in the area where the Covered Services were rendered, BCI will base the payment on the local plan's Preferred Provider Organization payment arrangement and allow In-Network benefits. The Provider shall not make an additional charge to an Insured for amounts in excess of BCI's payment except for Deductibles, Coinsurance, Copayments, and noncovered services.

2. If the Provider does not have a PPO agreement for claims payment with the Blue Cross and/or Blue Shield plan in the area where the Covered Services are rendered, BCI will base payment on the Out-of-Network schedule and allow Out-of-Network benefits. The Provider is not obligated to accept BCI's payment as payment in full. BCI is not responsible for the difference, if any, between BCI's payment and the actual charge.

C. A Contracting Covered Provider rendering Covered Services shall not make an additional charge to an Insured for amounts in excess of BCI's payment except for Deductibles, Coinsurance, Copayments, and noncovered services.

D. A Noncontracting Covered Provider inside or outside the state of Idaho is not obligated to accept BCI's payment as payment in full. BCI is not responsible for the difference, if any, between BCI's payment and the actual charge, unless otherwise specified. Insureds are responsible for any such difference, including Deductibles, Coinsurance, Copayments, charges for noncovered services and the amount charged by the Noncontracting Covered Provider that is in excess of BCI's Maximum Allowance.

E. Emergency Services

For the treatment of Emergency Medical Conditions or Accidental Injuries of sufficient severity to necessitate immediate medical care by, or that require Ambulance Transportation Service to, the nearest appropriate Facility Provider, BCI, on behalf of the Plan Administrator, will provide In-Network benefits for Covered Services provided by either a Contracting or Noncontracting Facility Provider and facility-based Professional Providers only. If the nearest Facility Provider is Noncontracting, once the Insured is stabilized, and it is medically safe to do so, the Insured (at BCI's option, on behalf of the Plan Administrator) may be required to transfer to the nearest appropriate Contracting Facility Provider for further care in order to continue to receive In-Network benefits for Covered Services. If the Insured is required to transfer, transportation to the Contracting Facility Provider will be a Covered Service under the Ambulance Transportation Service provision of this Plan.

VISION CARE BENEFITS SECTION

This section specifies the benefits an Insured is entitled to receive for the Covered Services described, subject to the other provisions of this Policy. If this Policy contains a provision stating that benefits are not available until the Insured has satisfied a waiting period for Preexisting Conditions, that provision does not apply to nor limit the benefits available under this section.

I. Benefit Limit and Limitations on Frequency of Services

The benefit limits for Vision Care Covered Services rendered by a Participating or a Nonparticipating VSP Doctor, and the Maximum Allowance that VSP will pay or otherwise satisfy are shown in the Benefits Outline.

II. Covered Providers

The following are Covered Providers under this section:

- Optometrist
- Physician

III. Procedures for Obtaining Covered Services

A. When an Insured uses a Vision Service Plan (VSP) Participating Doctor the Insured must make an appointment to receive Covered Services. No preauthorization or special benefit form is required. The doctor will verify eligibility and obtain the necessary authorization from VSP.

B. In emergency cases (where immediate vision care is necessary) an Insured may obtain Covered Services by contacting a VSP Participating Doctor without prior approval or authorization from VSP. The Insured must inform the VSP Participating Doctor of VSP coverage.

C. An Insured may also obtain vision Covered Services from a provider other than VSP Participating Doctors.

IV. Covered Services

When rendered by a Covered Provider, benefits are provided for the following services:

Eye Examination
Frame
Single Vision Lenses
Bifocal Lenses
Trifocal Lenses
Lenticular Lenses
Contact Lenses in place of eyeglasses

A. Eye Examination

An eye vision examination regardless of its Medical Necessity, could include but not be limited to, the following services:

(NOTE: Each test may not be indicated for every patient.)

1. **Intermediate Examination**—brief or limited routine check-up or vision survey.
2. **Vision Analysis**—various tests for prescription Lenses.
3. **Tonometry**—measurement of eye tension for glaucoma.
4. **Biomicroscopy**—examination of the living eye tissue.
5. **Central and/or Peripheral Field Study**—measurement of visual acuity in the central and/or peripheral field of vision.

B. Prescribed Lenses and Frames

When an eye examination indicates that new Lenses or a new Frame or both are necessary for the proper visual health and welfare of an Insured, they will be supplied, together with such professional services as necessary, which include but are not limited to:

1. Prescribing and ordering proper Lenses.
2. Assisting in the selection of a Frame.
3. Verifying the accuracy of the finished Lenses.
4. Proper fitting and adjustment of the eyeglasses.

VSP reserves the right to limit the cost of Frames provided by VSP Participating Doctors. The allowance is published periodically by VSP to its Participating Doctors and is set at a level to cover

the majority of Frames in common use. If an Insured wishes to select a more expensive Frame than allowed in this section, the difference in cost is not the responsibility of VSP or Blue Cross of Idaho (BCI).

C. Contact Lenses

1. **Medically Necessary Contact Lenses**—Contact Lenses are furnished when the VSP Participating Doctor receives prior approval from VSP for any of the following:
   a) Following cataract Surgery.
   b) To correct extreme visual acuity problems that cannot be corrected with eyeglass Lenses.
   c) Certain conditions of Anisometropia.
   d) Keratoconus.

   Medically Necessary Contact Lenses once furnished as described above can be replaced only upon prior authorization by VSP.
2. **Elective Contact Lenses**—If an Insured chooses Contact Lenses from a VSP Participating Doctor for reasons other than those mentioned above, VSP provides benefits as follows: The initial basic examination will be covered in full (as described under Eye Examination) and an allowance will be paid toward a contact lens evaluation fee, fitting costs, and materials in place of the benefits described for Prescribed Lenses and Frames. The allowance amount is shown in the Benefits Outline.
3. **Reimbursement Allowances**—For Covered Services rendered by a Provider who is not a VSP Doctor, a determination of Medically Necessary versus Elective Contact Lenses will be consistent with VSP Participating Doctor services. Reimbursement allowances for Medically Necessary and Elective Contact Lenses include a contact lens evaluation fee, fitting costs, and materials and is in place of all other benefits for materials, including eyeglass Lenses and Frame.

V. Amount of Payment Provisions

A. For Covered Services rendered by a Contracting Provider, the Insured must pay for any additional services received not covered by this Policy. VSP will pay the Participating Doctor in accordance with the agreement between VSP and the Participating Doctor.

B. If Covered Services are rendered by a Provider who is not a VSP Participating Doctor, the Insured shall be responsible for paying the Provider in full. The Insured will be reimbursed in accordance with the benefits available, if any, as shown in the Benefits Outline.

A Provider who is not a VSP Participating Doctor is not obligated to accept VSP's payment as payment in full. VSP and Blue Cross of Idaho (BCI) are not responsible for the difference, if any, between VSP's payment and the actual charge, any such difference is the Insured's responsibility.

C. The amounts shown in the Benefits Outline under payment for services rendered are maximums. The actual amount paid in reimbursement to the Insured is either the amount indicated in the Benefits Outline, the amount actually charged, or the amount usually charged by the Provider of such services to his or her private patients, whichever is less.

VI. Definitions

A. **Anisometropia**—a condition of unequal refractive state for the two (2) eyes, one (1) eye requiring a different lens correction that the other.

B. **Blended Lenses**—bifocals that do not have a visible dividing line.

C. **Coated Lenses**—a substance added to a finished lens on one (1) or both surfaces.

D. **Contact Lenses**—ophthalmic corrective Lenses. They must be prescribed by an Optometrist or Physician to be directly fitted to the Insured's eye.

E. **Frame**—a standard eyeglass Frame adequate to hold Lenses.

F. **Keratoconus**—a developmental or dystrophic deformity of the cornea in which it becomes cone-shaped due to a thinning and stretching of the tissue in its central area.

G. **Lenses**—ophthalmic corrective Lenses (either glass or plastic). They must be prescribed by an Optometrist or Ophthalmologists to improve visual acuity or performance and to be fitted to a Frame. Amounts payable are based on a lens blank not more than sixty-one (61) millimeters in diameter, tinted no darker than the equivalent of Pink #1 or #2 and without photosensitive or anti-reflective properties.

H. **Orthoptics**—the teaching and training process for improvement of visual perception and coordination of the two (2) eyes for efficient and comfortable binocular vision.

I. **Photochromic Lenses**—Lenses that change color with intensity of sunlight.

J. **Plano Lenses**—Lenses that have no refractive power.

K. **Tinted Lenses**—Lenses that have an additional substance added to produce constant tint.

L. **VSP Participating Doctor**—an Optometrist or Physician who is a member panelist of Vision Service Plan (VSP).

VII. Exclusions and Limitations

In addition to any other exclusions and limitations of this Policy, the following exclusions and limitations apply to this particular section and throughout the entire Policy, unless otherwise specified:

A. **Enrollee's Options**

When an Insured selects any of the following options, VSP pays the basic cost of the allowed Lenses, and the Insured is responsible for paying the additional costs for the following options:

1. Blended Lenses.
2. Contact Lenses, except as provided in this section.
3. Oversize Lenses.
4. Photochromic Lenses.
5. Tinted Lenses except Pink #1 and Pink #2.
6. Progressive multi-focal Lenses.
7. Coating of the lens or Lenses.
8. Laminating of the lens or Lenses.
9. A Frame that costs more than the VSP allowance.
10. Cosmetic Lenses.
11. Optional cosmetic processes.
12. UV (ultraviolet) protected Lenses.

B. **Not Covered**

No benefits are available for professional services or materials connected with:

1. Orthoptics or vision training and any associated supplemental testing.
2. Plano lenses (less than a $\pm$.38 diopter power).
3. Two pair of glasses in lieu of bifocals.
4. Replacement of lenses and frames furnished under this Policy which are lost or broken, except at the normal intervals when services are otherwise available.
5. Medical or surgical treatment of the eyes.
6. Corrective vision treatment of an Experimental nature.
7. Low vision services and materials.
8. Plano contact lenses to change eye color cosmetically.
9. Costs for services and/or materials above VSP allowances.
10. Artistically-painted contact lenses.
11. Contact lens modification, polishing or cleaning.
12. Additional office visits associated with contact lens pathology.
13. Contact lens insurance policies or service agreements.
14. Services and/or materials not indicated specifically as Covered Services.

INTEGRATED BEHAVIORAL HEALTH PLAN (IBHP) BENEFITS SECTION

This section specifies the benefits an Insured is entitled to receive for Covered Services described, subject to the other provisions of this Policy. If this Policy contains a provision stating that benefits are not available until the Insured has satisfied a waiting period for Pre-existing Conditions, that provision does not apply to nor limit the benefits available under this section.

The IBHP Benefits are shown in the Benefits Outline.

All requests for Pre-authorization and inquiries for EAP, Mental Health and/or Substance Abuse Services must be directed to Business Psychology Associates, 208-343-4180 or 1-877-427-2327.

I. Benefits Administrator

Benefits for the Employee Assistance Program (EAP) and Mental Health and Substance Abuse Services are administered by Business Psychology Associates (BPA). These benefits are referred to as Integrated Behavioral Health Plan (IBHP) Benefits.

II. Pre-Authorization Requirement

All of the benefits described in this Integrated Behavioral Health Plan Benefit Section require Pre-authorization from BPA. Pre-authorization may be obtained by calling the toll-free number indicated in this section and on the Blue Cross of Idaho membership card. All IBHP Insureds have rights and responsibilities. Among them is the Right to Appeal any decision made by BPA.

BPA professional staff will make an initial assessment of an Inured's problem, refer the Insured to a behavioral health professional in the Insured's community and authorize the duration and setting for the care. If the Insured changes Providers or receives treatment in different settings, BPA's professional staff will coordinate care for the Insured through these changes. BPA will follow well-established protocols and clinical criteria and work closely and cooperatively with the Providers treating each Insured.

III. Definitions

The following Definitions apply only to this particular section of this Policy.

A. **Appropriate Level of Care** means that, in keeping with the generally accepted norms for psychiatric practice in the United States, the level and intensity of mental health care where services performed are not more than, or less than, that required for the patient's present condition.

B. **Assessment** means those procedures by which a program evaluates an individual's strengths, weaknesses, problems or needs.

C. **Authorization of Care** means the determination that, based on clinically valid criteria, care provided to a BPA beneficiary, or proposed to be provided to a BPA beneficiary, is medically and psychologically necessary, provided at the appropriate level and otherwise meets BPA requirements for payment of benefits.

E. **Clinical Review** means the review of information regarding a patient's condition, diagnosis, treatment, progress and prognosis which is obtained from medical records and/or telephonic interviews with the attending Provider or representative of an inpatient facility, to arrive at a decision regarding the medical/psychological necessity and the appropriateness of care.

F. **Coinsurance** means the percentage of the Maximum Allowance or the actual charge, whichever is less, an Insured is responsible to pay Out-of-Pocket for Covered Services after satisfaction of any applicable Deductibles or Copayments, or both.

G. **Concurrent Review** means a review that is performed after the Pre-admission Review and during an Insured's hospitalization to determine the medical necessity and appropriateness of continuing the Insured's stay at a previously authorized level of care or during an episode of outpatient treatment. In the case of hospitalization, it may be referred to as a continued stay review.

H. **Confidentiality** means the degree and circumstance by which information obtained through diagnostic or therapeutic interventions between the Insured and Providers are protected from public disclosure. Protections will conform to the provisions of the Freedom of Information Act, the Privacy Act, the Confidentiality of Drug Abuse, Alcohol, Sickle Cell Anemia and HIV/AIDS Treatment Record and HIPAA required security and privacy provisions.

I. **Contracting Provider** means a Provider that has contracted with BPA to provide services set forth in this Benefit Section.

J. **Copayment** means a designated dollar and/or percentage amount, separate from Coinsurance, that an Insured is financially responsible for and must pay to a Provider at the time certain Covered Services are rendered.

K. **Covered Service** means a Pre-authorized treatment, commodity, or supply specified in this Benefit Section for which benefits will be provided when rendered by a Provider.

L. **Criteria** means Predetermined elements of health care, developed by health professionals relying on professional expertise, prior experience and the professional literature with each aspects of quality, medical necessity and appropriateness of a health care service may be compared.

M. **Deductible** means the amount of charges, up to the Maximum Allowance, for Covered Services payable by an Insured to a Provider recognized for payment under this Benefit Section before BPA will assume any liability for all or part of the remaining Covered Services.

N. **Emergency** means a situation, as determined by an examining physician or psychologist, requiring treatment due to the sudden onset of a condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate psychiatric care (within twenty-four [24] hours of onset) would result in permanently placing the Insured's life in jeopardy of serious and permanent impairment or dysfunction.

O. **Employee Assistance Program (EAP) Benefit** means the services identified and provided under Plan Services Specific to the EAP section of this Benefit Section.

P. **Hospital** means a specialized Inpatient facility licensed and approved as such by the State for mental or neuropsychiatric and/or substance abuse treatment and care by or under the supervision of a staff of licensed physicians. A Hospital under this definition is not, other than incidentally, a place for rest, a nursing home, or a facility for convalescence.

Q. **In-Network Hospital** means a Hospital that has contracted with BPA.

R. **In-Network Provider** means a Provider who has contracted with BPA.

S. **In-Network Services** are services performed by an In-Network Provider or an In-Network Hospital.

T. **Inpatient** means an Insured who is admitted to a Hospital for treatment and who is so confined in such Hospital for a period of twenty-four (24) hours or more and/or for whom a room charge is made.

U. **Integrated Behavioral Health Plan (IBHP)** means a coordinated benefit that includes both Employee Assistance Program services and Mental Health and Substance Abuse Services.

V. **Maximum Allowance** means for Covered Services under the terms of this Benefit Section. Maximum Allowance is the lesser of the billed charge or the amount established as the highest level of compensation for a Covered Service.

The Maximum Allowance is determined using many factors, including pre-negotiated payment amounts; diagnostic related groupings (DRGs); a resource based relative value scale (RBRVS); the Provider's charge(s); the charge(s) of Providers with similar training and experience within a

particular geographic area; Medicare reimbursement amounts; and/or the cost of rendering the Covered Service.

W. **Medically Necessary** means those services or supplies provided by a Provider that are required to identify or treat an Insured's illness and that, as determined by BPA, are:

1. Consistent with the symptoms, diagnosis, and/or treatment of the Insured's condition;
2. Appropriate with regard to standards of good medical practice recognized and approved at the time employed by physicians practicing within the state of Idaho as accepted medical/psychiatric practice;
3. Not primarily for the convenience of an Insured or Provider; and
4. The most appropriate supply or level of service that can be safely provided to the Insured. When applied to the care of an Inpatient, Medically Necessary further means that the Insured's symptoms or conditions require that the services cannot be safely provided to the Insured as an Outpatient. The fact that a Provider may prescribe, order, recommend, or approve a service or supply does not, of itself, render such service or supply Medically Necessary or coverable under this Benefit Section.

X. **Mental Health and Substance Abuse Services** means the services identified and provided under this Benefit Section specific to Mental Health and Substance Abuse Services.

Y. **Out-of-Network Hospital** means a Hospital that has not contracted with BPA.

Z. **Out-of-Network Provider** means a Provider who has not contracted with BPA. Out-of-Network Providers may not be obligated to accept BPA's reimbursement as payment in full and may be paid at a lesser amount than In-Network Providers. The Insured is responsible for any additional non-covered amounts if Covered Services are provided by Out-of-Network Providers.

AA. **Out-of-Network Services** are services performed by an IBHP Out-of-Network Provider.

AB. **Outpatient** means services rendered in the Provider's office or at the Hospital when the Insured is not admitted to the Hospital for a period of more than twenty-four (24) hours.

AC. **Plan** means the services identified and provided under this Benefit Section.

AD. **Pre-admission Review** means a Clinical Review that is performed prior to or at the time of a patient's hospitalization with the goal of establishing medical necessity.

AE. **Pre-authorized** means the receipt of authorization from BPA to receive Covered Services prior to the delivery of the Covered Services. Insureds must call for Pre-authorization for all Covered Services. Pre-authorization does not guarantee payment for Covered Services.

AF. **Provider** means a person or entity that makes available the Covered Services set forth in this Benefit Section to Insureds. For purposes of this Benefit Section, covered Providers shall include only the following when practicing within the scope of individual licensure:

1. Psychiatrist;
2. Psychologist;
3. Licensed Professional Counselor and/or LCPC;
4. Certified Social Worker;
5. Service Extender;
6. Licensed Marriage and Family Therapist;
7. Master's Level Certified Alcohol and Drug Counselor;
8. Master's Level Substance Abuse Provider;
9. Hospital (free-standing psychiatric, substance abuse and/or general medical facility with psychiatric beds) or;
10. Psychiatric Nurse or Nurse Practitioner under supervision of a Psychiatrist.

AG. **Quality Assurance** means, with respect to medical care provided to BPA beneficiaries, the process of ensuring, to the extent possible, that the care is medically necessary and appropriate, is financially

reasonable and that the care falls within the generally accepted norms of medical practice of competent practitioners.

AH. **Service Extender** means a person who meets the requirements to be an assistant to a licensed psychologist as set forth in Section H of the Rules and Regulations of the Idaho State Board of Psychologist Examiners and who provides services to treat mental or neuropsychiatric conditions and who is: (1) a licensed professional counselor with a current license issued by the Idaho State Counselor Licensing Board pursuant to Idaho Code 54-3405, or (2) a Certified Social Worker licensed by the Idaho State Board of Social Work Examiners pursuant to Idaho Code 54-3206.

AI. **Technical Denial** means a denial of Authorization of Care due to insufficient and inadequate clinical information upon which to base a decision regarding the medical necessity and appropriateness of care (sometimes called an administrative denial). A technical denial is an initial determination and, as such, may be appealed.

AJ. **Urgent Care** means a condition requiring immediate action, although not necessarily a life-threatening condition. An urgent care condition is a situation that has the potential to become an emergency in the absence of immediate treatment.

AK. **URAC** is the Utilization Review Accreditation Committee.

IV. Eligibility

All active Employees of the State of Idaho and all their Eligible Dependents are enrolled in the Employee Assistance Program (EAP) portion of the IBHP.

Active Employees and Eligible Dependents enrolled in the State of Idaho employer sponsored group medical plan under this Policy have access to Medically Necessary Mental Health and Substance Abuse Services.

V. General Information

A. How to Submit Claims

To receive benefits for covered services, the Insured must submit a claim. There are two ways to submit a claim:

1. The Insured's Provider (Hospital, doctor, or other facility or specialist) can file it for the Insured. Most providers will submit a claim on the Insured's behalf because care was Pre-authorized and they received notice from BPA to show where the Provider should submit the claim.
2. The Insured can send BPA the claim. If the Insured files their own claim, all the Insured needs to do:
   - Ask the doctor or Hospital for an itemized billing. This should show each service received and its procedure code, the date the service was furnished, and the charge for each service. BPA cannot handle billings that only say "Balance Due," "Payment Received" or something similar.
   - Obtain a Member Reimbursement form by calling BPA at 1-877-427-2327, and follow the instructions on it. Use a separate billing and Member Reimbursement form for each patient involved.
   - Attach the billing to the Member Reimbursement form and send it to the address shown on the form.

B. How BPA Notifies the Insured

BPA will send the Insured an Explanation of Benefits as soon as BPA processes a claim. The Explanation of Benefits will show all the payments BPA made, and to whom BPA sent the payments. It will also explain any charges BPA could not pay in full.

C. Questions or Inquiries

Call BPA's Boise office if the Insured has questions about benefits or a payment. The toll-free telephone number is **1-877-427-2327**. The Boise calling area is **343-4180**. BPA's telephone hours are 8:00 a.m. to 6:00 p.m. Monday through Thursday and 8:00 a.m. to 5:00 p.m. on Friday, Mountain

Standard Time (MST). BPA is available twenty-four (24) hours a day, seven days a week for the purpose of coordinating any necessary care. Or the Insured may write BPA's Customer Support Department at the following address: Business Psychology Associates, 300 E. Mallard Dr., Suite 350, Boise, ID 83706.

D. A Provider directory can be found at www.bpahealth.com.

E. IBHP Appeals

In the event an Insured disputes any decision concerning services, pre-authorization and/or claims provided or denied by BPA, the Insured has the right to appeal such decision.

IBHP Appeals will be jointly reviewed and processed by BCI and BPA. Refer to the Inquiry and Appeals Procedures outlined in the General Provision Section of this Policy. Written appeals may be directed to:

Appeals and Grievance Coordinator
BPA
300 E. Mallard Drive, Suite 350
Boise, Idaho 83706

VI. Employee Assistance Program Benefits

The IBHP offers up to five (5) sessions with no co-payment under the EAP Benefit when Pre-authorization has been obtained.

BPA will provide the full range of EAP services, including problem assessment, intervention, diagnosis, counseling, referral and follow-up. Counseling services will be provided for a broad range of problem areas, including, but not limited to, job related stress, marital, emotional, family, physical, alcohol or drug related problems.

BPA agrees to provide screening and counseling services as defined below. Services are designed to help the Insured cope with any mental health, chemical dependency, marital, family, legal or financial problems they might be facing and which could affect employee performance.

- *Individual Short Term Counseling*. BPA will provide counseling services for a broad range of problem areas, including substance abuse, job related or occupational issues, stress, depression, family, legal and financial difficulties.
- *Conflict Resolution/Mediation*. BPA will provide a forum in which supervisors and/or employees can develop or improve working relationships. This service is usually for two (2) or three (3) employees and, if requested, the supervisor.
- *Critical Incident Stress Debriefing (CISD).* CISD provides an on-site response following a tragic or critical incident, such as the death of a co-worker or supervisor. This type of service can involve several sessions and larger groups of employees. Urgent counseling can be arranged for individuals.
- *Critical Incident Stress Management.* This type of service is designed to help employees handle issues that are not tragic in nature but have a critical impact on the work environment. This type of service can be conducted on site and may include a larger group of individuals.

BPA shall, through its network of Providers, identify quality community service providers to whom referrals from the Contract Providers can be made. These community service providers should be accommodating to limitations in insurance coverage and within the financial means of the Insured. BPA shall utilize professional counselors and other resources nearest to where the Insured lives.

Referral to an appropriate Contracting Provider will be made upon clinically appropriate determination of the need for further counseling services. Whenever possible, Insureds will be referred to In-Network-Providers. When referrals are made to Out-of-Network Providers, BPA will contact such Provider and facilitate the referral by arranging the initial appointment or otherwise assisting the Insured. In all cases where a referral is made outside of the IBHP, the enrolled individual will be responsible for the financial cost of any subsequent services. The staff of BPA will assist the EAP user in locating the most appropriate services that are within their financial means and consistent with any other health care benefits.

VII. Mental Health And Substance Abuse Benefits

BPA shall administer or arrange for the delivery of Inpatient and Outpatient Mental Health and Substance Abuse Services under this section.

Mental health services shall include, except as specifically excluded in this section, diagnostic or therapeutic services (whether organic or inorganic, biological, nonbiological, chemical or nonchemical in origin, and irrespective of cause, basis or inducement) for the treatment of mental disorders, mental illnesses, psychiatric illnesses, mental conditions and psychiatric conditions. This includes, but is not limited to, the following conditions: psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

Substance abuse services shall include, except as specifically excluded in this section, diagnostic or therapeutic services for the treatment of a mental or physical disorder manifested by repeated excessive use of a drug or alcohol to the extent that it interferes with health, social or economic functioning.

The following rules apply to the Mental Health and Substance Abuse Benefit:

- An Insured must get Pre-authorization from BPA before obtaining Mental Health and Substance Abuse Services. Pre-authorization staff will be available twenty-four (24) hours a day.
- In-Network and Out-of-Network Services that are not pre-authorized as provided above shall be the sole responsibility of the Insured. If an Insured is admitted on an emergency basis, the Insured or his/her provider has 24 hours (or the next business day) within which to obtain authorization.
- The Mental Health and Substance Abuse Services will not cover medical/surgical procedures, prescription drugs or any services rendered by a primary care physician or any other non-mental health physician.

  Medication management provided by the Insured's family physician is not covered by the Insured's Integrated Behavioral Health Plan (IBHP) benefit. Services provided by a family physician are subject to the Comprehensive Major Medical Section of this Policy.

VIII. Deductible

The benefits of this Benefit Section shall apply commencing with the first day treatment in a Benefit Period for which treatment has been Pre-authorized hereunder, after the following conditions have been fulfilled:

A. Before an Insured shall qualify for the benefits of this Benefit Section, such Insured must have paid, subsequent to the effective date of coverage under this Benefit Section, the Deductible amount shown in the Benefits Outline for each Benefit Period in which the benefits of this Benefit Section apply. In calculating whether the Deductible requirements have been fulfilled, only amounts, up to the Maximum Allowance, of Pre-authorized services actually paid by the Insured during the current Benefit Period shall be considered.

B. The Deductible applies to all Pre-authorized Mental Health and Substance Abuse Services except care provided by the EAP.

C. Charges for services payable by the Insured due to a reduction of benefits, denial of benefits, for treatment that was not Pre-authorized, or amounts charged in excess of the Maximum Allowance are the financial responsibility of the Insured and shall not be considered as an eligible expense for application towards the Deductible amount.

D. To qualify for the benefits of this Benefit Section, the Insured shall submit proof to BPA that the applicable Deductible amount for the Benefit Period involved has been incurred including name of Provider, diagnosis, and itemized statements.

IX. Copayments

The benefits provided under this Benefit Section include Copayment/Coinsurance amounts that are the responsibility of the Insured. The Copayment/Coinsurance amounts are shown in the Benefits Outline.

A. Outpatient, In-Network Services involve a per billable hour Copayment. This includes medication management services that may actually take less than one (1) hour to administer, yet are considered a billable hour of service under this Benefit Section.

B. Inpatient, In-Network Services involve a per hour Copayment.

C. Intensive Outpatient, In-Network Services involve a per hour Copayment.

D. All Out-of-Network services are subject to Coinsurance for the services provided. In addition to this Coinsurance amount, the Insured is also responsible for any charges in excess of the Maximum Allowance.

X. Service Providers

BPA agrees that the physician and other mental health and substance abuse professionals utilized by BPA in meeting its obligations under this Policy shall hold appropriate degrees, licenses and certifications, consistent with community and URAC standards, to perform the duties and responsibilities assigned to them. BPA has reviewed credentialing requirements and BPA agrees to conduct the selection of its providers in a manner consistent with these credentialing requirements.

BPA shall establish contractual relationships with mental health and substance abuse treatment providers and facilities. These Contracting Providers shall not seek additional payment, except for applicable Copayments, Coinsurance and Deductibles. Out-of-Network Providers are not obligated to accept BPA's reimbursement as payment in full and BPA is not responsible for the difference, if any between BPA's payment and the Out-of-Network Provider's charge, unless specified. Insureds are responsible for any such differences, including Deductible, Coinsurance and Copayments.

XI. Utilization Management

The following utilization management activities related to the Mental Health and Substance Abuse Services described in this Benefit Section will be used in the delivery of services to all enrollees.

BPA has a written Utilization Management Plan that describes its activities and includes nationally verified approved Level of Care Guidelines utilized in making Pre-authorization determinations. BPA's Utilization Management Program is accredited by the Utilization Review Accreditation Committee (URAC).

The Utilization Management Plan includes:

A. Policies and procedures to evaluate medical necessity and criteria used in decisions regarding level and type of care;

B. A procedure for the review of policies and procedures;

C. A procedure for the evaluation and adjudication of complaints, appeals and grievances;

D. A procedure for Pre-authorization of services to enrollees; and

E. A procedure for utilization decisions rendered to be clearly documented with a timely written notification to the Provider and the Enrollee

F. All BPA service Pre-authorizations and concurrent authorization decisions are approved by an appropriate licensed and qualified clinician.

All denials of service authorizations for clinical reasons are approved by a licensed physician or psychologist based upon medical necessity.

All utilization management decisions are clearly documented with regard to the data and rationale used by the reviewer in making the decision, and the decision rendered is clearly documented with written notification to the Provider and the Insured.

All written denials shall be accompanied by a statement advising the Provider or Insured of their right to an appeal or grievance, and how to initiate such an appeal or grievance.

A system for monitoring the consistency in the application of criteria across reviewers is in place.

Utilization management decisions will be rendered in a timely manner. Routine requests will be rendered within three (3) days for ambulatory services. Routine Inpatient requests will be rendered within one (1) business day. Urgent requests will be rendered within twenty-four (24) hours. Emergency requests will be rendered within the same business day.

XIII. Exclusions

In addition to any other exclusions and limitations of this Policy, the following exclusions apply to this particular section and throughout the entire Policy, unless otherwise specified.

The Insured's Mental Health and Substance Abuse Services will not cover the following treatments:

A. Smoking cessation, except as provided as an EAP service.

B. Weight loss, physical fitness and weight management programs.

C. Court-ordered treatment, or as a condition of parole or probation (unless medically necessary).

D. Psychoanalysis to complete a degree or residency requirements.

E. Experimental treatment or treatment performed for the purpose of research.

F. Marriage counseling, except as provided as an EAP service.

G. Pastoral, spiritual or bereavement counseling.

H. Psychological testing for educational purposes.

I. Vocational and educational training and/or services.

J. Hypnosis for non-DSM-IV classified disorders.

K. Custodial care.

L. Treatment, services, conditions, supplies or other charges not considered medically necessary for the Insured's diagnosis.

M. Treatment provided by acupuncturist, naturopaths, audiologists, massage therapists, Christian Science services, pastoral counselors, and homeopathic physicians.

N. Counseling for adoption, custody, family planning or pregnancy in the absence of a psychiatric diagnosis, except as provided as an EAP service.

O. Recreational therapy.

P. Bio-Energetic therapy, Confrontation therapy, Crystal Healing therapy, Educational Remediation, Guided Imagery, Primal therapy, Rolfing, or other therapies and providers not first approved for their medical necessity.

Q. Aversion therapy, carbon dioxide therapy, environmental ecological therapy, narcotherapy, and sedative-action electro-stimulation therapy.

R. Residential treatment for mental health diagnoses, unless Pre-authorized as a short-term alternative to Mental Health and Substance Abuse Services in-patient care.

S. Conditions without a recognizable DSM-IV diagnostic classification.

T. Conditions classified as "V-codes" in the DSM-IV classification.

U. Conditions arising from the following developmental disorders — mental retardation, autism, academic skills disorders, motor skills disorders, organic brain disorders in which demonstrable and significant improvement through psychiatric treatment is unlikely.

V. If both a husband and wife are employed by the State of Idaho and are eligible for benefits, each must be covered only as an Enrolled Employee and may not additionally be covered as a Dependent.

W. Dependent children may only be enrolled under the coverage of one parent, not both.

XIV. Pre-Existing Condition Waiting Period

The IBHP has no preexisting condition waiting period.

PRESCRIPTION DRUG BENEFITS SECTION

This section specifies the benefits an Insured is entitled to receive for Covered Services described, subject to the other provisions of this Policy.

I. Prescription Drug Copayment/Coinsurance

For the types and levels of benefits coverage regarding Prescription Drug Copayments and/or Coinsurance, see the Benefits Outline.

Maintenance Prescription Drugs:

For a thirty (30)-day or less supply of a Maintenance Prescription Drug, the Insured is responsible for paying one (1) Copayment amount.

For a thirty-one (31)-day to ninety (90)-day supply of a Maintenance Prescription Drug, the Insured is responsible for paying two (2) Copayment amounts.

Non-maintenance Prescription Drugs:

For Prescription Drugs, other than a Maintenance Prescription Drug, the Insured is responsible for paying one (1) Copayment amount for each covered prescription.

II. Covered Providers

The following are Covered Providers under this section:
Licensed Pharmacist
Participating Pharmacy/Pharmacist
Physician

III. Dispensing Limitations

Each covered prescription for a Maintenance Prescription Drug is limited to no more than a ninety (90)-day supply. All other covered prescriptions are limited to no more than a thirty (30)-day supply. However, prescriptions and Prescription Drugs may be subject to more restrictive quantity limits.

IV. Amount Of Payment

A. The amount of payment for a covered Prescription Drug dispensed by a Participating Pharmacist is the balance remaining after subtracting the Prescription Drug Copayment from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.

B. For a covered Prescription Drug dispensed by a Physician or a Licensed Pharmacist who is not a Participating Pharmacist, the Insured is responsible for paying for the Prescription Drug at the time of purchase and must submit a claim to BCI or one (1) of its designated claims processing vendors. The amount of payment for a covered Prescription Drug is the balance remaining after subtracting the Prescription Drug Copayment and/or Coinsurance from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.

V. Generic Drug

Certain Prescription Drugs are restricted to Generics for payment by BCI. Even if the Insured, the Physician, or other duly licensed Provider requests the Brand Name Drug, the Insured is responsible for the difference between the price of the Generic and the Brand Name Drug, plus any applicable Brand Name Drug Copayment/Coinsurance.

VI. Utilization Review

Prescription Drug benefits include utilization review of Prescription Drug usage for the Insured's health and safety. If there are patterns of over-utilization or misuse of drugs the Insured's personal Physician and Pharmacist will be notified. BCI reserves the right to limit benefits to prevent over-utilization or misuse of Prescription Drugs.

VII. Preauthorization

Certain Prescription Drugs may require preauthorization. If the Insured's Physician or other Provider prescribes a drug, which requires preauthorization, the Insured will be informed by the Provider or Pharmacist. To obtain preauthorization the Insured's Physician must write a letter to BCI or its designated agent, describing the Medical Necessity for the prescription. Within a reasonable period of time, but no later than fifteen (15) days after BCI or its designated agent, receives a request for preauthorization, BCI or its designated agent, will notify the Insured and/or the attending Provider(s) of its determination, or BCI or its designated agent, may request additional information necessary to make an informed determination.

VIII. Covered Services

Prescription Drugs approved by the Pharmacy and Therapeutics Committee, compounded medication of which at least one (1) ingredient is a Prescription Drug, Pharmacy Supplies, insulin, and any other drug that, under applicable state law, may be dispensed only upon written prescription of a Physician, when the drugs or medicines are directly related to the treatment of an Illness, Disease, medical condition or Accidental Injury and are dispensed by a Licensed Pharmacist or Physician on or after the Insured's Effective Date. Benefits for Prescription Drugs are available up to the limits stated in Item III. of this section.

Covered prescription drugs include oral contraceptives for the Enrollee or the Enrolled Eligible Dependent spouse.

IX. Definitions

A. **Allowed Charge**—the amount payable for a Prescription Drug as determined by the reimbursement formula agreed upon between the Participating Pharmacist and one (1) or more of BCI's designated claims processing vendors.

B. **Brand Name Drug**—a Prescription Drug, approved by the FDA, that is protected by a patent and is marketed and supplied under the manufacturer's brand name.

C. **Generic Drug**—a Prescription Drug, approved by the FDA, that has the same active ingredients, strength, and dosage as its Brand Name Drug counterpart.

D. **Maintenance Prescription Drug**—a Prescription Drug, as determined by BCI or its designated agent, that an Insured takes on a regular or long-term basis for treatment of a chronic or on-going medical condition. It is not a Prescription Drug that an Insured takes for treatment of an acute medical condition.

E. **Participating Pharmacy/Pharmacist**—a Licensed Pharmacist or retail pharmacy that has a contract with one (1) or more of BCI's designated claims processing vendors for the purpose of providing Prescription Drug Covered Services to Insureds under this Policy.

F. **Pharmacy And Therapeutics Committee**—a committee of Physicians and Licensed Pharmacists established by BCI that recommends policy regarding the evaluation, selection, and therapeutic use of various drugs. The Committee and BCI may also review, deny or determine alternative benefits for newly FDA approved prescription drugs, biological agent or other agents.

G. **Pharmacy Supplies**—supplies that can be purchased at a Participating Pharmacy using the Insured's pharmacy benefit. Includes: strips; lancets; alcohol swabs; insulin syringes/needles; insulin in bottles and cartridges for insulin pens; and insulin pens.

H. **Prescription Drugs**—drugs, biologicals and compounded prescriptions that are FDA approved and can be dispensed only according to a written prescription given by a Physician and/or duly licensed provider, that are listed and accepted in the *United States Pharmacopeia, National Formulary,* or *AMA Drug Evaluations* published by the American Medical Association (AMA), that are prescribed for human consumption, and that are required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription."

I. **Usual Charge**—the lowest retail price being charged by a Licensed Pharmacist for a Prescription Drug at the time of purchase by an Insured.

X. Exclusions And Limitations

In addition to any other exclusions and limitations of this Policy, the following exclusions and limitations apply to this particular section and throughout the entire Policy, unless otherwise specified.

If an Insured also has a Prescription Drug benefit under a stand-alone Prescription Drug program, Prescription Drug benefits under this Policy are limited to the Insured's Out-of-pocket expenses under the stand-alone Prescription Drug program, up to the Prescription Drug benefit available under this Policy.

No benefits are provided for the following:

1. Contraceptives, oral or other, whether medication or device, and regardless of intended use -- except as specifically stated in this Policy or that are clearly Medically Necessary for the treatment of a medical condition which requires the use of hormone therapy.
2. Drugs used for the termination of early pregnancy, and complications arising therefrom, except when required to correct an immediately life-endangering condition.
3. Over-the-counter drugs other than insulin, even if prescribed by a Physician.
4. Charges for the administration or injection of any drug.
5. Therapeutic devices or appliances, including hypodermic needles, syringes (except for insulin syringes/needles), support garments, and other non-medicinal substances, regardless of intended use.
6. Drugs labeled "Caution—Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made to the Insured.
7. Immunization agents, biological sera, blood or blood plasma. Benefits may be available under the Major Medical Benefits Section of this Policy.
8. Medication that is to be taken by or administered to an Insured, in whole or in part, while the Insured is an Inpatient in a Licensed General Hospital, rest home, sanatorium, Skilled Nursing Facility, extended care facility, convalescent hospital, nursing home, or similar institution which operates or allows to operate on its premises, a facility for dispensing pharmaceuticals.
9. Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one (1) year from the Physician's original order.
10. Any newly FDA approved Prescription Drug, biological agent, or other agent until it has been reviewed and approved by BCI's Pharmacy and Therapeutics Committee.
11. Any Prescription Drug, biological or other agent, that is:
    a) Prescribed primarily to aid or assist the Insured in the cessation of the use of tobacco.
    b) Prescribed primarily to aid or assist the Insured in weight loss, including all anorectics, whether amphetamine or nonamphetamine.
    c) Prescribed primarily to retard the rate of hair loss or to aid in the replacement of lost hair.
    d) Prescribed primarily to increase fertility, including but not limited to, drugs which induce or enhance ovulation.
    e) Prescribed primarily for personal hygiene, comfort, beautification, or for the purpose of improving appearance.
    f) Prescribed primarily to increase growth, including but not limited to, growth hormone. Benefits are available for this Therapy Service under the Major Medical Benefits Section of this Policy only as preauthorized and approved when Medically Necessary.
    g) Provided by or under the direction of a Home Intravenous Therapy Company, Home Health Agency or other Provider approved by BCI. Benefits are available for this Therapy Service under the Major Medical Benefits Section of this Policy only as preauthorized and approved when Medically Necessary.

ELIGIBILITY AND ENROLLMENT SECTION

I. Eligibility and Enrollment

All Eligible Employees will have the opportunity to apply for coverage under this Policy. All applications submitted to Blue Cross of Idaho (BCI) by the Group now or in the future, shall be for Eligible Employees or Eligible Dependents only. Once enrolled under the Policy, Eligible Employees may not change to another Policy until an Open Enrollment Period.

A. Eligible Employee

Employees who are officers or employees of state agencies, departments, or institutions, including state officials, elected officials, or employees of other governmental entities which have contracted with the State of Idaho for medical expense coverage, who are working twenty (20) hours or more per week, or eighty-four (84) hours per month, and whose term of employment is expected to exceed five (5) months in any consecutive twelve (12) month period. Employees hired on or after the effective date of this Policy will have coverage for him or herself and their Dependent effective the first day of the month following ninety (90) days of employment, provided enrollment is completed within sixty (60) days of the date of hire. The following exception applies:

Benefits for employees rehired within twelve (12) months of the last date of employment who were eligible for benefits when last employed by the State, will be effective on the first day of the month following the date of rehire provided enrollment is completed within sixty (60) days of the date of rehire.

B. Eligible Dependent

Eligible Dependent means: (1) The spouse of the Enrollee and/or (2) the unmarried children of an Enrollee or Enrollee's spouse, up to their 19th birthdays. The term "children" includes natural children, stepchildren, adopted children, or children in the process of adoption from time placed with the Enrollee. The term "children" also includes children legally dependent upon the Enrollee or Enrollee's spouse for support where a normal parent-child relationship exists with the expectation that the Enrollee will continue to rear that child to adulthood. However, if one or both of that child's natural parents live in the same household with the Enrollee, a parent-child relationship shall not be deemed to exist even though the Enrollee or the Enrollee's spouse provides support. Such children may be covered beyond their 19th birthdays so long as they are unmarried and are eligible to be claimed as dependents on the Enrollee's most recent U.S. Individual Income Tax return, but not beyond the end of the calendar month in which they attain age twenty-three (23).

C. Conditions

1. An Eligible Employee’s spouse may not enroll in this plan if said spouse is an Eligible Employee of the Group and enrolled in any other Health Benefit Plan offered by the Group.
2. Under special circumstances approved by the Group, other children under the custodial care of the Enrollee may be considered as Eligible Dependent(s).
3. If both parents are Eligible Employees of the Group and enrolled in any Health Benefit Plan offered by the Group, eligible dependent children may be enrolled under one or the other parent’s policy, but not both.
4. An Enrollee must notify BCI within thirty (30) days when a dependent no longer qualifies as an Eligible Dependent. Coverage for the former Eligible Dependent will terminate the last day of the month in which the change in eligibility status took place.

II. Group Contribution

If applicable, the Group agrees to pay the appropriate percentage of the premium for each enrolled Insured, as determined through legislative appropriations. The employee shall authorize the Group to withhold, deduct or collect the monthly payment and remit such payments to BCI in accordance with the application form submitted by each employee. In the event of COBRA, Leave of Absence Without Pay, or other circumstances, the Enrollee may be required to pay the entire premium.

III. Miscellaneous Eligibility and Enrollment Provisions

A. The Group agrees to collect required Enrollee payments through payroll withholding and be responsible for making the required payments to BCI. If, during the Benefit Period, the Group offers to its employees any other hospital, medical, or surgical coverage that is available to the Group from BCI, but not provided by or through BCI, including but not limited to, coverage under a fee for service/indemnity plan, managed care organization or other similar program or plan, BCI, at its sole option and upon thirty (30) days written notice to the Group, may recalculate the required premiums for the Group's Insureds. Thereafter, the Group must timely pay the recalculated premiums to maintain coverage under this Policy.

B. Before the effective date of the change, the Group shall submit all eligibility changes for Enrollees and Eligible Dependents on a BCI approved form (electronic application, e-mail, etc.). It is the Group's responsibility to verify that all Insureds are eligible for coverage as specified in this Policy.

C. For an Eligible Employee to enroll himself or herself and any Eligible Dependents for coverage under this Policy (or for an Enrollee to enroll Eligible Dependents for coverage) the Eligible Employee or Enrollee, as the case may be, must complete a BCI application and submit it through the Group to BCI.

D. Except as provided otherwise in this section and after completion of any applicable eligibility waiting period as determined by the Group, the Effective Date of coverage for an Eligible Employee or an Eligible Dependent will be the first day of the month following the month of enrollment.

E. The Effective Date of coverage for an Eligible Employee and any Eligible Dependents listed on the Eligible Employee’s application is the Group's Policy Date if the application is submitted to BCI by the Group on or before the Policy Date.

F. A disabled Enrolled Employee shall be able to maintain his or her coverage up to thirty (30) months following the date of disability upon payment of appropriate premium.

G. BCI will waive the time period applicable to the Preexisting Condition waiting period (set forth in this Policy’s Exclusions and Limitations Section) with respect to particular Covered Services for the period of time an Insured was previously covered by Qualifying Previous Coverage that provided benefits with respect to such Covered Services, provided that the Qualifying Previous Coverage was continuous to a date not more than sixty-three (63) days prior to the Enrollment Date under this Policy. This paragraph does not preclude the application of an eligibility waiting period applicable to all new employees under this Policy.

H.

1. Except as provided otherwise in subparagraphs H2. and H3. below, the initial enrollment period is sixty (60) days for Eligible Employee and Eligible Dependents. The initial enrollment period begins on the date the Eligible Employee or Eligible Dependent first becomes eligible for coverage under this Policy.
2. The initial enrollment period is sixty (60) days for an Eligible Dependent who is an Enrollee's newborn natural child, or child who is adopted by the Enrollee, or placed for adoption with the Enrollee before age eighteen (18). The initial enrollment period begins with the date of birth, adoption or placement for adoption. The Preexisting Condition waiting period (set forth in this Policy’s Exclusions and Limitations Section) does not apply to such an Eligible Dependent who enrolls during the applicable initial enrollment period.

The Effective Date of coverage will be the date of birth for a newborn natural child, a child adopted or placed for adoption within sixty (60) days of the child's date of birth, provided the child is enrolled during the applicable initial enrollment period. If the date of adoption or the date of placement for adoption of a child is more than sixty (60) days after the child's date of birth, the Effective Date of coverage will be the date of adoption or the date of placement for adoption, provided the child is enrolled during the applicable initial enrollment period. In this Policy, "placed for adoption" means physical placement in the care of the adoptive Enrollee, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it means when the adoptive Enrollee signs an agreement for adoption of the child and signs an agreement assuming financial responsibility for the child.

3. The initial enrollment period is sixty (60) days for an Eligible Dependent who becomes eligible because of marriage. The initial enrollment period begins on the date of such marriage. The Effective Date of coverage will be the first day of the month following the date of marriage.

I. Late Enrollee

If an Eligible Employee or an Eligible Dependent does not enroll during the applicable initial enrollment period described in Paragraph E. of this section, the Eligible Employee or Eligible Dependent is a Late Enrollee. The Effective Date of coverage for a Late Enrollee will be the first day of the month following the receipt and acceptance of a completed enrollment application. However, an Eligible Employee or Eligible Dependent is not a Late Enrollee if:

1. The Eligible Employee or Eligible Dependent meets each of the following:
   a) The individual was covered under Qualifying Previous Coverage at the time of the initial enrollment period.
   b) The individual lost coverage under Qualifying Previous Coverage as a result of termination of employment or eligibility, the involuntary termination of the Qualifying Previous Coverage.
   c) The individual requests enrollment within thirty (30) days after termination of the Qualifying Previous Coverage.
2. The individual is employed by an employer that offers multiple Health Benefit Plans and the individual elects a different plan during an open enrollment period.
3. A court has issued a court order requiring that coverage be provided for an Eligible Dependent by an Enrollee under this Policy, and application for enrollment is made within thirty (30) days after issuance of the court order.
4. The individual first becomes eligible.

IV. Qualified Medical Child Support Order

A. If this Policy provides for family coverage, BCI will comply with a Qualified Medical Child Support Order (QMCSO) according to the provisions of Section 609 of ERISA and any other applicable federal or state laws. A medical child support order is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a child of an Enrollee under this Policy or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law) and relates to benefits under this Policy, or
2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to a group health plan.

B. A medical child support order meets the requirements of a QMCSO if such order clearly specifies:

1. The name and the last known mailing address (if any) of the Enrollee and the name and mailing address of each child covered by the order.
2. A reasonable description of the type of coverage to be provided by this Policy to each such child, or the manner in which such type of coverage is to be determined.
3. The period to which such order applies.

C. Within fifteen (15) days of receipt of a medical child support order, BCI will notify the party who sent the order, the group administrator and each affected child of the receipt and of the criteria by which

BCI determines if the medical child support order is a QMCSO. With respect to a medical child support order, affected children may designate a representative for receipt of copies of notices sent to each of them.

D. BCI will make benefit payments to the respective party for reimbursement of eligible expenses paid by an enrolled affected child or by an enrolled affected child's custodial parent, legal guardian, or the Idaho Department of Health and Welfare.

DEFINITIONS SECTION

For reference, most terms defined in this section are capitalized throughout this Policy. Other terms may be defined where they appear in this Policy. All Providers and Facilities listed in this Policy and in the following section must be licensed and/or registered by the state where the services are rendered and must be performing within the scope of license in order for BCI to provide benefits. Definitions in this Policy shall control over any other definition or interpretation unless the context clearly indicates otherwise.

Accidental Injury—an objectively demonstrable impairment of bodily function or damage to part of the body caused by trauma from a sudden, unforeseen external force or object, occurring at a reasonably identifiable time and place, and without an Insured's foresight or expectation, which requires medical attention at the time of the accident. The force may be the result of the injured party's actions, but must not be intentionally self-inflicted unless caused by a medical condition or domestic violence. Contact with an external object must be unexpected and unintentional, or the results of force must be unexpected and sudden.

Acute Care—Medically Necessary Inpatient treatment in a Licensed General Hospital or other Facility Provider for sustained medical intervention by a Physician and Skilled Nursing Care to safeguard an Insured's life and health. The immediate medical goal of Acute Care is to stabilize the Insured's condition, rather than upgrade or restore an Insured's abilities.

Adverse Benefit Determination—any denial, reduction or termination of, or the failure to provide payment for, a benefit for services or ongoing treatment under this Policy.

Alcoholism—a behavioral or physical disorder manifested by repeated excessive consumption of alcohol to the extent that it interferes with an Insured's health, social, or economic functioning.

Ambulatory Surgical Facility—a Facility Provider, with a staff of Physicians, which:

1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis.
2. Provides treatment by or under the supervision of Physicians and provides Skilled Nursing Care while the Insured is in the facility.
3. Does not provide Inpatient accommodations appropriate for a stay of longer than twelve (12) hours.
4. Is not primarily a facility used as an office or clinic for the private practice of a Physician or other Professional Provider.

Artificial Organs—permanently attached or implanted man-made devices that replace all or part of a Diseased or nonfunctioning body organ, including but not limited to, artificial hearts and pancreases.

Autotransplant (or Autograft)—the surgical transfer of an organ or tissue from one (1) location to another within the same individual.

Benefit Period—the period of time from July 1 to June 30 of the following year, unless otherwise noted, during which an Insured accumulates annual benefit limits, Deductible amounts and Out-of-pocket Limits and may receive Covered Services.

Blue Cross of Idaho Health Service, Inc. (Blue Cross of Idaho or BCI)—a nonprofit mutual insurance company.

BlueCard—a program to process claims for most Covered Services received by Insureds outside of BCI's service area while capturing the local Blue Cross and/or Blue Shield Plan's Provider discounts.

Certified Nurse-Midwife—an individual licensed to practice as a Certified Nurse Midwife.

Certified Registered Nurse Anesthetist—an individual registered as a Certified Registered Nurse Anesthetist.

Chiropractic Care—services rendered, referred, or prescribed by a Chiropractic Physician.

Chiropractic Physician—an individual licensed to practice chiropractic.

Clinical Nurse Specialist—an individual licensed to practice as a Clinical Nurse Specialist.

Coinsurance—the percentage of the Maximum Allowance or the actual charge, whichever is less, an Insured is responsible to pay Out-of-pocket for Covered Services after satisfaction of any applicable Deductibles or Copayments, or both.

Comprehensive Lifetime Benefit Limit—the greatest aggregate amount payable by BCI, on behalf of an Insured for all Covered Services during all periods in which the Insured has been enrolled or covered under any agreement, certificate, contract, or policy issued or administered by BCI on behalf of the Group. Payments applied toward specific Lifetime Benefit Limits also apply toward the all-inclusive Comprehensive Lifetime Benefit Limit.

Congenital Anomaly—a condition existing at or from birth, which is a significant deviation from the common form or function, whether caused by a hereditary or a developmental defect. In this Policy, Congenital Anomalies include cleft lips, cleft palates, birthmarks, webbed fingers or toes, and other conditions that BCI may determine to be Congenital Anomalies. In no event will the term Congenital Anomaly include conditions relating to the teeth or intra-oral structures supporting the teeth.

Continuous Crisis Care—Hospice Nursing Care provided during periods of crisis in order to maintain a terminally ill Insured at home. A period of crisis is one in which the Insured's symptom management demands predominantly Skilled Nursing Care.

Contracting Provider—a Provider that has entered into an agreement with BCI regarding payment for Covered Services rendered to an Insured under a Preferred Blue PPO program.

Copayment—a designated dollar and/or percentage amount, separate from Coinsurance, that an Insured is financially responsible for and must pay to a Provider at the time certain Covered Services are rendered.

Covered Provider—a Provider specified in this Policy from whom an Insured must receive Covered Services in order to be eligible to receive benefits.

Covered Service—when rendered by a Covered Provider, a service, supply, or procedure specified in this Policy for which benefits will be provided to an Insured.

Custodial Care—care designated principally to assist an Insured in engaging in the activities of daily living; or services which constitute personal care, such as help in walking and getting in and out of bed, assistance in eating, dressing, bathing, and using the toilet; preparation of special diets; and supervision of medication, which can usually be self-administered and does not require the continuing attention of trained medical or paramedical personnel. Custodial Care is normally, but not necessarily, provided in a nursing home, convalescent home, rest home, or similar institution.

Deductible—the amount an Insured is responsible to pay Out-of-pocket before BCI begins to pay benefits for Covered Services. The amount credited to the Deductible is based on the Maximum Allowance or the actual charge, whichever is less.

Dentist—an individual licensed to practice Dentistry.

Dentistry or Dental Treatment—the treatment of teeth and supporting structures, including but not limited to, the replacement of teeth.

Diagnostic Service—a test or procedure performed on the order of a Physician or other Professional Provider because of specific symptoms, in order to identify a particular condition, Disease, Illness, or Accidental Injury. Diagnostic Services, include but are not limited to:

1. Radiology services.
2. Laboratory and pathology services.
3. Cardiographic, encephalographic, and radioisotope tests.

Disease—any alteration in the body or any of its organs or parts that interrupts or disturbs the performance of vital

functions, thereby causing or threatening pain, weakness, or dysfunction. A Disease can exist with or without an Insured's awareness of it, and can be of known or unknown cause(s).

Durable Medical Equipment—items which can withstand repeated use, are primarily used to serve a therapeutic purpose, are generally not useful to a person in the absence of Accidental Injury, Disease or Illness, and are appropriate for use in the Insured's home.

Durable Medical Equipment Supplier—a business that sells or rents Durable Medical Equipment.

Effective Date—the date when coverage for an Insured begins under this Policy.

Eligible Dependent—(1) the spouse of the Enrollee and/or (2) the unmarried children of an Enrollee or Enrollee's spouse, up to their 19th birthdays. The term "children" includes natural children, stepchildren, adopted children, or children in the process of adoption from time placed with the Enrollee. The term "children" also includes children legally dependent upon the Enrollee or Enrollee's spouse for support where a normal parent-child relationship exists with the expectation that the Enrollee will continue to rear that child to adulthood. However, if one or both of that child's natural parents live in the same household with the Enrollee, a parent-child relationship shall not be deemed to exist even though the Enrollee or the Enrollee's spouse provides support. Such children may be covered beyond their 19th birthdays so long as they are unmarried and are eligible to be claimed as dependents on the Enrollee's most recent U.S. Individual Income Tax return, but not beyond the end of the calendar month in which they attain age twenty-three (23).

Eligible Employee—employees who are officers or employees of state agencies, departments, or institutions, including state officials, elected officials, or employees of other governmental entities which have contracted with the State of Idaho for medical expense coverage, who are working twenty (20) hours or more per week, or eighty-four (84) hours per month, and whose term of employment is expected to exceed five (5) months in any consecutive twelve (12) month period. Employees hired on or after the effective date of this Policy will have coverage for him or herself and their Dependent effective the first day of the month following ninety (90) days of employment, provided enrollment is completed within sixty (60) days of the date of hire. The following exception applies:

- Benefits for employees rehired within twelve (12) months of the last date of employment who were eligible for benefits when last employed by the State, will be effective on the first day of the month following the date of rehire.

Emergency Inpatient Admission—Medically Necessary Inpatient admission to a Licensed General Hospital or other Inpatient Facility due to the sudden, acute onset of a medical condition or an Accidental Injury which requires immediate medical treatment to preserve life or prevent severe, irreparable harm to an Insured.

Emergency Medical Condition—a condition in which sudden and unexpected symptoms are sufficiently severe to necessitate immediate medical care. Emergency Medical Conditions, include but are not limited to, heart attacks, cerebrovascular accidents, poisonings, loss of consciousness or respiration, and convulsions.

Emergency or Maternity Admission Notification—notification by the Insured to BCI of an Emergency Inpatient Admission resulting in an evaluation conducted by BCI to determine the Medical Necessity of an Insured's Emergency Inpatient Admission or unscheduled maternity admission, and the accompanying course of treatment.

Enrollee—an Eligible Employee who has enrolled for coverage and has satisfied the requirements of the Eligibility and Enrollment Section.

Enrollment Date—the date of enrollment of an Eligible Employee or Eligible Dependent under this Policy, or if earlier, the first day of the eligibility waiting period for such enrollment.

Family—means two (2) or more persons related by blood, marriage, or law who are enrolled under the same identification number.

Freestanding Dialysis Facility—a Facility Provider that is primarily engaged in providing dialysis treatment, maintenance, or training to patients on an Outpatient or home care basis.

Group—the State of Idaho as represented by the Department of Administration.

Health Benefit Plan—any hospital or medical policy or certificate, any subscriber contract provided by a hospital or professional service corporation, or managed care organization subscriber contract. Health Benefit Plan does not include policies or certificates of insurance for specific Disease, hospital confinement indemnity, accident-only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, student health benefits-only coverage issued as a supplement to liability insurance, Workers' Compensation or similar insurance, automobile medical payment insurance, or nonrenewable short-term coverage issued for a period of twelve (12) months or less.

Homebound—confined primarily to the home as a result of a medical condition. The term connotes that it is "a considerable and taxing effort" to leave the home due to a medical condition and not because of inconvenience.

Home Health Agency—any agency or organization that provides Skilled Nursing Care services and other therapeutic services.

Home Health Aide—an individual employed by a Contracting Hospice, under the direct supervision of a licensed registered nurse (R.N.), who performs and trains others to perform, intermittent Custodial Care services which include but are not limited to, assistance in bathing, checking vital signs, and changing dressings.

Home Health Nursing—the delivery of Skilled Nursing services under the direction of a Physician to a Homebound patient in their home on an intermittent basis. Home Health Nursing is generally intended to transition a Homebound patient from a hospital setting to a home or prevent a hospital stay.

Home Intravenous Therapy Company—a Provider principally engaged in providing Skilled Nursing Care services, medical supplies, and equipment for certain covered home infusion Therapy Services, to patients in their homes or other locations outside of a hospital.

Hospice—a public agency or private organization designated to provide services for care and management of terminally ill patients, primarily in the home.

Hospice Nursing Care—Skilled Nursing Care and Home Health Aide services provided as a part of the Hospice Plan of Treatment.

Hospice Plan of Treatment—a written plan of care that describes the services and supplies for the Medically Necessary palliative care and treatment to be provided to an Insured by a Hospice. The written plan of care must be established and periodically reviewed by the attending Physician.

Hospice Therapy Services—Hospice Therapy Services include only the following:

1. Hospice Physical Therapy—the treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles, and devices to relieve pain, to enable an Insured to maintain basic functional skills and to manage symptoms
2. Respiratory Therapy
3. Speech Therapy

Hypnosis—an induced passive state in which there is an increased responsiveness to suggestions and commands, provided that these do not conflict seriously with the subject's conscious or unconscious wishes.

Illness—a deviation from the healthy and normal condition of any bodily function or tissue. An Illness can exist with or without an Insured's awareness of it, and can be of know or unknown cause(s).

In-Network Services—Covered Services provided by a Contracting Provider.

Inpatient—an Insured who is admitted as a bed patient in a Licensed General Hospital or other Facility Provider and for whom a room and board charge is made.

Insured—an Enrollee or an enrolled Eligible Dependent covered under this Policy.

Investigational—any technology (service, supply, procedure, treatment, drug, device, facility, equipment or biological product), which is in a developmental stage or has not been proven to improve health outcomes such as length of life,

quality of life, and functional ability. A technology is considered investigational if, as determined by BCI, it fails to meet any one of the following criteria:

- The technology must have final approval from the appropriate government regulatory body. This applies to drugs, biological products, devices, and other products/procedures that must have approval from the U.S. Food and Drug Administration (FDA) or another federal authority before they can be marketed. Interim approval is not sufficient. The condition for which the technology is approved must be the same as that BCI is evaluating.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of current published medical literature and investigations published in peer-reviewed journals. The quality of the studies and consistency of results will be considered. The evidence should demonstrate that the technology can measure or alter physiological changes related to a Disease, injury, Illness, or condition. In addition, there should be evidence that such measurement or alteration affects health outcomes.
- The technology must improve the net health outcome. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
- The technology must be as beneficial as any established alternatives.
- The technology must show improvement that is attainable outside the investigational setting. Improvements must be demonstrated when used under the usual conditions of medical practice.

If a technology is determined to be investigational, all services specifically associated with the technology, including but not limited to associated procedures, treatments, supplies, devices, equipment, facilities or drugs will also be considered investigational.

In determining whether a technology is investigational, BCI considers the following source documents: Blue Cross Blue Shield Association Technology Evaluation Center (TEC) assessments, the Blue Cross and Blue Shield Association Medical Policy Reference Manual as adopted by BCI, and Blue Cross of Idaho Medical Policies. BCI also considers, at its discretion, current published medical literature and peer review publications based upon scientific evidence, and evidence-based guidelines developed by national organizations and recognized authorities.

BCI reserves the right to interpret the meaning of the terms used in this definition and any policies or procedures, which support this definition.

Large Employer—any person, firm, corporation, partnership or association that is actively engaged in business that, on at least 50% of its working days during the preceding Benefit Period, employed no less than fifty-one (51) Eligible Employees, the majority of whom were employed within Idaho. In determining the number of Eligible Employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one (1) employer.

Licensed General Hospital—a short term, Acute Care, general hospital that:

1. Is an institution licensed in the state in which it is located and is lawfully entitled to operate as a general, Acute Care hospital.
2. Is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians, for compensation from and on behalf of its patients.
3. Has functioning departments of medicine and Surgery.
4. Provides twenty-four (24)-hour nursing service by or under the supervision of licensed R.N.s.
5. Is not predominantly a:
    a. Skilled Nursing Facility
    b. Nursing home
    c. Custodial Care home
    d. Health resort
    e. Spa or sanatorium
    f. Place for rest
    g. Place for the aged
    h. Place for the treatment or rehabilitative care of Mental or Nervous Conditions
    i. Place for the treatment or rehabilitative care of Alcoholism or Substance Abuse or Addiction
    j. Place for Hospice care

k. Residential Treatment Facility
l. Transitional Living Center

Licensed Pharmacist—an individual licensed to practice pharmacy.

Lifetime Benefit Limit—the greatest aggregate amount payable by BCI on behalf of an Insured for specified Covered Services during all periods in which the Insured has been enrolled or covered under any agreement, certificate, contract, or policy issued or administered by BCI on behalf of the Group. Payments applied toward specific Lifetime Benefit Limits also apply toward the all-inclusive Comprehensive Benefit Limit.

Maximum Allowance—for Covered Services under the terms of this Policy, Maximum Allowance is the lesser of the billed charge or the amount established as the highest level of compensation for a Covered Service. If the Covered Services are rendered outside the state of Idaho by a provider contracting with a Blue Cross and/or Blue Shield affiliate in the location of the Covered Services, the Maximum Allowance is the lesser of the billed charge or the amount established by the affiliate as compensation. If the Covered Services are rendered outside the state of Idaho by a provider not contracting with a Blue Cross and/or Blue Shield affiliate in the location of the Covered Service, the Maximum Allowance is the lesser of the billed charge or the amount established by BCI as compensation for a Covered Service.

The Maximum Allowance is determined using many factors, including pre-negotiated payment amounts; diagnostic related groupings (DRGs); a resource based relative value scale (RBRVS); the Provider's charge(s); the charge(s) of Providers with similar training and experience within a particular geographic area; Medicare reimbursement amounts; and/or the cost of rendering the Covered Service. Moreover, Maximum Allowance may differ depending on whether the Provider is Contracting or Noncontracting.

In addition, Maximum Allowance for Covered Services provided by Contracting or Noncontracting Dentists is determined using many factors, including pre-negotiated payment amounts, a calculation of charges submitted by Contracting Idaho Dentists, and/or a calculation of the average charges submitted by all Idaho Dentists.

Medically Necessary (or Medical Necessity)— the Covered Services or supplies required to identify or treat an Insured's condition, Disease, Illness or Accidental Injury and which, as recommended by the treating Physician or other Covered Provider and as determined by BCI, are:

1. The most appropriate supply or level of service, considering potential benefits and harms to the Insured.
2. Proven to be effective in improving health outcomes;
   a. For new treatments, effectiveness is determined by scientific evidence;
   b. For existing treatments, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion.
3. Not primarily for the convenience of the Insured or Covered Provider.
4. Cost-effective for this condition, compared to alternative treatments, including no treatment. Cost-effectiveness does not necessarily mean lowest price.

When applied to the care of an Inpatient, it further means that the Insured's medical symptoms or condition are such that the services cannot be safely and effectively provided to the Insured as an Outpatient.

The fact that a Covered Provider may prescribe, order, recommend, or approve a service or supply does not, in and of itself, necessarily establish that such service or supply is Medically Necessary under this Policy.

The term Medically Necessary as defined and used in this Policy is strictly limited to the application and interpretation of this Policy, and any determination of whether a service is Medically Necessary hereunder is made solely for the purpose of determining whether services rendered are Covered Services.

Mental or Nervous Conditions—means and includes mental disorders, mental Illnesses, psychiatric Illnesses, mental conditions, and psychiatric conditions (whether organic or inorganic, whether of biological, nonbiological, chemical or nonchemical origin and irrespective of cause, basis, or inducement). Mental and Nervous Conditions, include but are not limited to: psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. See Integrated Behavioral Health Plan Benefits Section.

Noncontracting Provider—a Professional Provider or Facility Provider that has not entered into an agreement with BCI regarding payment for Covered Services rendered to an Insured under this PPO program.

Nurse Practitioner—an individual licensed to practice as a Nurse Practitioner.

Occupational Therapist—an individual licensed to practice occupational therapy.

Open Enrollment Period—an enrollment period, as specified by the Group, when an Enrollee may change benefit plan options, i.e. move from the Traditional plan to the PPO.

Optometrist—an individual licensed to practice optometry.

Organ Procurement—Diagnostic Services and medical services to evaluate or identify an acceptable donor for a recipient and a donor's surgical and hospital services directly related to the removal of an organ or tissue for such purpose. Transportation for a donor or for a donated organ or tissue is not an Organ Procurement service.

Orthotic Devices—any rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or Diseased body part.

Out-of-Network Services—any Covered Services rendered by a Noncontracting Provider.

Out-of-pocket Limit—the amount of Out-of-pocket expenses incurred during one (1) Benefit Period that an Insured is responsible for paying. Eligible Out-of-pocket expenses include only the Insured's Deductible and Coinsurance for eligible Covered Services.

Outpatient—an Insured who receives services or supplies while not an Inpatient.

Pain Rehabilitation—an intensive Inpatient program administered by qualified health care professionals, under the orders of an attending Physician, to an Insured who is suffering chronic, intractable pain (regardless of its origin) which has failed to respond to medical or surgical treatment. Pain Rehabilitation is intended to teach the Insured how to control and cope with pain and regain normal function.

Physical Rehabilitation—Medically Necessary non-acute therapy rendered by qualified health care professionals. Physical Rehabilitation is intended to restore an Insured's physical health and well-being as close as reasonably possible to the level that existed immediately prior to the occurrence of a condition, Disease, Illness, or Accidental Injury.

Physical Rehabilitation Plan of Treatment—a written plan which describes the services and supplies for the Physical Rehabilitation care and treatment to be provided to an Insured. The written plan must be established and periodically reviewed by an attending Physician.

Physical Therapist—an individual licensed to practice physical therapy.

Physician—a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) licensed to practice medicine.

Physician Assistant—an individual licensed to practice as a Physician Assistant.

Podiatrist—an individual licensed to practice podiatry.

Policy—this Policy, which includes only the Benefits Outline, individual enrollment applications, Insured identification cards, any written endorsements, riders, amendments, or any other written agreements between BCI and the Group executed by an authorized officer of BCI and the Group.

Policy Date—the date specified in this Policy on which coverage commences for the Group (July 1).

Post-Service Claim—any claim for a benefit under this Policy that does not require prior approval or preauthorization before services are rendered.

Preadmission Testing—tests and studies required in connection with an Insured's Inpatient admission to a Licensed

General Hospital that are rendered or accepted by the Licensed General Hospital on an Outpatient basis. Preadmission tests and studies must be done prior to a scheduled Inpatient admission to the Licensed General Hospital, provided the services would have been available to an Inpatient of that hospital. Preadmission Testing does not include tests or studies performed to establish a diagnosis.

Preexisting Condition—a physical or mental condition, regardless of the cause, for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) months preceding the Enrollment Date. A pregnancy existing on the Enrollment Date is not a Preexisting Condition under this Policy. Genetic information is not considered a Preexisting Condition in the absence of a diagnosis of the condition related to such information.

Preferred Blue PPO—a preferred provider organization product offered through BCI.

Prescription Drugs—drugs, biologicals, and compounded prescriptions that can be dispensed only according to a written prescription given by a Physician, that are listed with approval in the *United States Pharmacopeia, National Formulary* or *AMA Drug Evaluations* published by the American Medical Association (AMA), that are prescribed for human consumption, and that are required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription."

Pre-Service Claim—any claim for a benefit under this Policy that requires prior approval or preauthorization before services are rendered.

Primary Care Giver—a person designated to give direct care and emotional support to an Insured as part of a Hospice Plan of Treatment. A Primary Care Giver may be a spouse, relative, or other individual who has personal significance to the Insured. A Primary Care Giver must be a volunteer who does not expect or claim any compensation for services provided to the Insured.

Prior Authorization—the Provider's request to BCI, or delegated entity, for authorization of an Insured's proposed treatment. BCI may review medical records, test results and other sources of information to ensure that it is a Covered Service and make a determination as to Medical Necessity or alternative treatments.

Prosthetic Appliances—Prosthetic Appliances are devices that replace all or part of an absent body organ, including contiguous tissue, or replace all or part of the function of a permanently inoperative or malfunctioning body organ.

Provider—a person or entity that is licensed, where required, to render Covered Services. For the purposes of this Policy, Providers include only the following:

1. Facility Providers
    a. Ambulatory Surgical Facility (Surgery Center)
    b. Contracting Electroencephalogram (EEG) Provider
    c. Contracting Hospice
    d. Contracting Licensed Rehabilitation Hospital
    e. Contracting Lithotripsy Provider
    f. Diagnostic Imaging Provider
    g. Freestanding Diabetes Facility
    h. Freestanding Dialysis Facility
    i. Home Health Agency
    j. Home Intravenous Therapy Company
    k. Independent Laboratory
    l. Licensed General Hospital
    m. Prosthetic and Orthotic Supplier
    n. Skilled Nursing Facility

2. Professional Providers
    a. Ambulance Transportation Service
    b. Certified Nurse-Midwife
    c. Certified Registered Nurse Anesthetist
    d. Chiropractic Physician
    e. Contracting Certified Speech Therapist
    f. Contracting Licensed Occupational Therapist

g. Contracting Licensed Physical Therapist
h. Clinical Nurse Specialist
i. Dentist/Denturist
j. Durable Medical Equipment Supplier
k. Licensed Pharmacist
l. Nurse Practitioner
m. Optometrist/Optician
n. Physician
o. Physician Assistant
p. Podiatrist

Qualifying Previous and Qualifying Existing Coverage—benefits or coverage provided under:

1. Medicare, Medicaid, Civilian Health and Medical Program for Uniformed Services (CHAMPUS), the Indian health service program, a state health benefit risk pool, or any other similar publicly sponsored program.
2. Any other Group or individual health insurance policy or health benefit arrangement (whether or not subject to the state insurance laws) including coverage provided by a managed care organization, hospital, or professional service corporation, or a fraternal benefit society.

Recognized Transplant Center—a Licensed General Hospital that meets any of the following criteria:

1. Is approved by the Medicare program for the requested Transplant Covered Services.
2. Is included in the Blue Cross and Blue Shield System's National Transplant Networks.
3. Has an arrangement(s) with another Blue Cross and/or Blue Shield Plan for the delivery of the requested Transplant Covered Services, based on appropriate approval criteria established by that Plan.
4. Is approved by BCI based on the recommendation of BCI's Medical Director.

Respite Care—care provided to a Homebound Insured as part of a Hospice Plan of Treatment. The purpose of Respite Care is to provide the Primary Care Giver a temporary period of rest from the stress and physical exhaustion involved in caring for the Insured at home.

Service Benefits Manager—Business Psychology Associates (BPA), a company under contract with BCI to administer mental health and substance abuse benefits to Enrollees.

Skilled Nursing Care—nursing service that must be rendered by or under the direct supervision of a licensed R.N. to maximize the safety of an Insured and to achieve the medically desired result according to the orders and direction of an attending Physician. The following components of Skilled Nursing Care distinguish it from Custodial Care that does not require professional health training:

1. The observation and assessment of the total medical needs of the Insured.
2. The planning, organization, and management of a treatment plan involving multiple services where specialized health care knowledge must be applied in order to attain the desired result.
3. Rendering to the Insured, direct nursing services that require specialized training.

Skilled Nursing Facility—a Facility Provider principally engaged in providing Inpatient Skilled Nursing Care to patients requiring convalescent care rendered by or under the supervision of a Physician. Other than incidentally, a Skilled Nursing Facility is not a place or facility that provides minimal care, Custodial Care, ambulatory care, or part-time care services; or care or treatment of Mental or Nervous Conditions, Alcoholism, or Substance Abuse or Addiction.

Special Care Unit—a designated unit within a Licensed General Hospital that has concentrated facilities, equipment, and support services to provide an intensive level of care for critically ill patients.

Substance Abuse or Addiction—a behavioral or physical disorder manifested by repeated excessive use of a drug or alcohol to the extent that it interferes with an Insured's health, social, or economic functioning. See Integrated Behavioral Health Plan Benefits Section.

Surgery—within the scope of a Provider's license, the performance of:

1. Generally accepted operative and cutting procedures.

2. Endoscopic examinations and other invasive procedures using specialized instruments.
3. The correction of fractures and dislocations.
4. Customary preoperative and postoperative care.

Therapy Services—Therapy Services include only the following:

1. Radiation Therapy—treatment of Disease by x-ray, radium, or radioactive isotopes.
2. Chemotherapy—treatment of malignant Disease by chemical or biological antineoplastic agents.
3. Renal Dialysis—treatment of an acute or chronic kidney condition, which may include the supportive use of an artificial kidney machine.
4. Physical Therapy—treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles, or devices to relieve pain, restore maximum function, or prevent disability following a condition, Disease, Illness, Accidental Injury, or loss of a body part.
5. Respiratory Therapy—treatments introducing dry or moist gases into the lungs.
6. Occupational Therapy—treatment that employs constructive activities designed and adapted for a physically disabled Insured to help him or her satisfactorily accomplish the ordinary tasks of daily living and tasks required by the Insured's particular occupational role.
7. Speech Therapy—corrective treatment of a speech impairment resulting from a condition, Illness, Disease, Surgery, or Accidental Injury; or from Congenital Anomalies, or previous therapeutic processes.
8. Enterostomal Therapy—counseling and assistance provided by a specifically trained enterostomal therapist to Insureds who have undergone a surgical procedure to create an artificial opening into a hollow organ (e.g., colostomy).
9. Growth Hormone Therapy—treatment administered by intramuscular injection to treat children with growth failure due to pituitary disorder or dysfunction.
10. Home Intravenous Therapy—treatment by intravenous injection, administered primarily at the Insured's home, at or under the direction of a Home Health Agency or other Provider approved by BCI.

Totally Disabled (or Total Disability)—as certified in writing by an attending Physician, a condition resulting from Disease, Illness or Accidental Injury causing:

1. An Enrollee's inability to perform the principal duties of the regular employment or occupation for which the Enrollee is or becomes qualified through education, training, or experience; and the Enrollee is not in fact engaged in any work profession, or avocation for fees, gain, or profit; or
2. An enrolled Eligible Dependent to be so disabled and impaired as to be unable to engage in the normal activities of an individual of the same age and gender.

Transplant—surgical removal of a donated organ or tissue and the transfer of that organ or tissue to a recipient.

EXCLUSIONS AND LIMITATIONS SECTION

In addition to the exclusions and limitations listed elsewhere in this Policy, the following exclusions and limitations apply to the entire Policy, unless otherwise specified.

I. General Exclusions and Limitations

There are no benefits for services, supplies, drugs or other charges that are:

A. Not specifically listed as a Covered Service.

B. Not Medically Necessary.

C. In excess of the Maximum Allowance.

D. For hospital Inpatient or Outpatient care for extraction of teeth or other dental procedures, unless necessary to treat an Accidental Injury or unless an attending Physician certifies in writing that the Insured has a non-dental, life-endangering condition which makes hospitalization necessary to safeguard the Insured's health and life.

E. Not prescribed by or upon the direction of a Physician or other Professional Provider; or which are furnished by any individuals or facilities other than Licensed General Hospitals, Physicians, and other Providers.

F. Investigational in nature.

G. Provided for any condition, Disease, Illness or Accidental Injury to the extent that the Insured is entitled to benefits under occupational coverage, obtained or provided by or through the employer under state or federal Workers' Compensation Acts, or under Employer Liability Acts, or other laws providing compensation for work-related injuries or conditions. This exclusion applies whether or not the Insured claims such benefits or compensation, or recovers losses from a third party.

H. Provided or paid for by any federal governmental entity except when payment under this Policy is expressly required by federal law, or provided or paid for by any state or local governmental entity where its charges therefore would vary, or would be affected by the existence of coverage under this Policy, or for which payment has been made under Medicare Part A and/or Medicare Part B, or would have been made if an Insured had applied for such payment except when payment under this Policy is expressly required by federal law.

I. Provided for any condition, Accidental Injury, Disease or Illness suffered as a result of any act of war or any war, declared or undeclared.

J. Furnished by a Provider who is related to the Insured by blood or marriage and who ordinarily dwells in the Insured's household.

K. Received from a dental, vision, or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.

L. For Surgery intended mainly to improve appearance or for complications arising from Surgery intended mainly to improve appearance, except for:

1. Reconstructive Surgery necessary to treat an Accidental Injury, infection, or other Disease of the involved part; or
2. Reconstructive Surgery to correct Congenital Anomalies in an Insured who is a dependent child.
3. Benefits for reconstructive Surgery to correct an Accidental Injury are available even though the accident occurred while the Insured was covered under a prior insurer's coverage, if there is no lapse between the prior coverage and coverage under this Policy.

M. Rendered prior to the Insured's Effective Date, or during an Inpatient Admission commencing prior to the Insured's Effective Date, except as specified in the General Provisions Section of this Policy.

N. For personal hygiene, comfort, beautification (including non-surgical services, drugs, and supplies intended to enhance the appearance), or convenience items or services even if prescribed by a Physician, including but not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment or programs, spas, hot tubs, whirlpool baths, waterbeds or swimming pools and therapies, including but not limited to, educational, recreational, art, aroma, dance, sex, sleep, electro sleep, vitamin, chelation, massage, or music.

O. For telephone consultations; and all computer or Internet communications; for failure to keep a scheduled visit or appointment; for completion of a claim form; or for personal mileage, transportation, food or lodging expenses or for mileage, transportation, food or lodging expenses billed by a Physician or other Professional Provider.

P. For Inpatient admissions that are primarily for Diagnostic Services or Therapy Services; or for Inpatient admissions when the Insured is ambulatory and/or confined primarily for bed rest, special diet, behavioral problems, environmental change, or for treatment not requiring continuous bed care.

Q. For Inpatient or Outpatient Custodial Care; or for Inpatient or Outpatient services consisting mainly of educational therapy, behavioral modification, self-care or self-help training, except as specified as a Covered Service in this Policy.

R. For any cosmetic foot care, including but not limited to, treatment of corns, calluses, bunions (except for surgical care) and toenails (except for surgical care of ingrown or Diseased toenails).

S. Related to Dentistry or Dental Treatment, even if related to a medical condition; or Orthoptics, eyeglasses or Contact Lenses, or the vision examination for prescribing or fitting eyeglasses or Contact Lenses.

T. For hearing aids or examinations for the prescription or fitting of hearing aids.

U. For any treatment of either gender leading to or in connection with transsexual Surgery, gender transformation, sexual dysfunction, or sexual inadequacy, including erectile dysfunction and/or impotence, even if related to a medical condition.

V. Made by a Licensed General Hospital for the Insured's failure to vacate a room on or before the Licensed General Hospital's established discharge hour.

W. Not directly related to the care and treatment of an actual condition, Illness, Disease or Accidental Injury.

X. Furnished by a facility that is primarily a place for treatment of the aged or that is primarily a nursing home, a convalescent home, or a rest home.

Y. For Acute Care, rehabilitative care, or diagnostic testing or evaluation of Mental or Nervous Conditions, Alcoholism, Substance Abuse or Addiction, or for Pain Rehabilitation, except as provided in the Integrated Behavioral Health Plan Benefits Section.

Z. Incurred by an Eligible Dependent child for care or treatment of any condition arising from or related to pregnancy, childbirth, delivery, or an Involuntary Complication of Pregnancy.

AA. Except as specified as a Covered Service in this Policy, for any of the following, even if it is a result of a Congenital Anomaly or a developmental problem and even if it is Medically Necessary—for appliances, splints or restorations necessary to increase vertical tooth dimensions or restore the occlusion; for orthognathic Surgery, including services and supplies to augment or reduce the upper or lower jaw; for implants in the jaw; for pain, treatment, or diagnostic testing or evaluation related to the misalignment or discomfort of the temporomandibular joint (jaw hinge), including splinting

services and supplies; or for alveolectomy or alveoloplasty when related to tooth extraction.

AB. For weight control or treatment of obesity or morbid obesity, even if Medically Necessary, including but not limited to Surgery for obesity. For reversals or revisions of Surgery for obesity, except when required to correct an immediately life-endangering condition.

AC. For use of operating, cast, examination, or treatment rooms or for equipment located in a Contracting or Noncontracting Provider's office or facility, except for Emergency room facility charges in a Licensed General Hospital, unless specified as a Covered Service in this Policy.

AD. For the reversal of sterilization procedures, including but not limited to, vasovasostomies or salpingoplasties.

AE. Treatment for infertility and fertilization procedures, including but not limited to, ovulation induction procedures and pharmaceuticals, artificial insemination, in vitro fertilization, embryo transfer or similar procedures, or procedures that in any way augment or enhance an Insured's reproductive ability.

AF. For Transplant services and Artificial Organs, except as specified as a Covered Service under this Policy.

AG. For acupuncture.

AH. For surgical procedures that alter the refractive character of the eye, including but not limited to, radial keratotomy, myopic keratomileusis, Laser-In-Situ Keratomileusis (LASIK), and other surgical procedures of the refractive-keratoplasty type, to cure or reduce myopia or astigmatism, even if Medically Necessary, unless specified as a Covered Service in a Vision Benefits Section of this Policy, if any. Additionally, reversals, revisions, and/or complications of such surgical procedures are excluded, except when required to correct an immediately life-endangering condition.

AI. For Hospice Home Care, except as specified as a Covered Service in this Policy.

AJ. For pastoral, spiritual, and bereavement counseling.

AK. For homemaker and housekeeping services or home-delivered meals.

AL. For the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation.

AM. For treatment or other health care of any Insured in connection with an Illness, Disease, Accidental Injury or other condition which would otherwise entitle the Insured to Covered Services under this Policy, if and to the extent those benefits are payable to or due the Insured under any medical payments provision, no fault provision, uninsured motorist provision, underinsured motorist provision, or other first party or no fault provision of any automobile, homeowner's, or other similar policy of insurance, contract, or underwriting plan.

In the event Blue Cross of Idaho (BCI) for any reason makes payment for or otherwise provides benefits excluded by the above provisions, it shall succeed to the rights of payment or reimbursement of the compensated Provider, the Insured, and the Insured's heirs and personal representative against all insurers, underwriters, self-insurers, or other such obligors contractually liable or obliged to the Insured, or his or her estate for such services, supplies, drugs or other charges so provided by BCI in connection with such Illness, Disease, Accidental Injury or other condition.

AN. Any services or supplies for which an Insured would have no legal obligation to pay in the absence of coverage under this Policy or any similar coverage; or for which no charge or a different charge is usually made in the absence of insurance coverage.

AO. For a routine or periodic mental or physical examination that is not connected with the care and

treatment of an actual Illness, Disease or Accidental Injury or for an examination required on account of employment; or related to an occupational injury; for a marriage license; or for insurance, school or camp application; or a screening examination, unless specified as a Covered Service under this Policy.

AP. For immunizations except as provided as a Covered Service under Wellness/Preventive Care Services in this Policy.

AQ. For breast reduction Surgery or Surgery for gynecomastia.

AR. For nutritional supplements, nutritional replacements, nutritional formulas, prescription vitamins and minerals.

AS. For an elective abortion, surgical or medical, or complications from an elective abortion, unless benefits for an elective abortion are specifically provided by a separate Endorsement to this Policy.

AT. For alterations or modifications to a home or vehicle.

AU. For special clothing, including shoes (unless permanently attached to a brace).

AV. Provided to a person enrolled as an Eligible Dependent, but who no longer qualifies as an Eligible Dependent due to a change in eligibility status that occurred after enrollment.

AW. Provided outside the United States, which if had been provided in the United States, would not be a Covered Service under this Policy.

AX. Furnished by a Provider or caregiver that is not listed as a Covered Provider, including but not limited to, Naturopaths.

AY. For Outpatient pulmonary and/or Outpatient cardiac rehabilitation.

AZ. For complications arising from the acceptance or utilization of noncovered services.

AAA. For the use of Hypnosis, as anesthesia or other treatment, except as specified as a Covered Service.

AAB. For dental implants, appliances, and/or prosthetics, and/or treatment related to Orthodontia, even when Medically Necessary, unless specified as a Covered Service in this Policy.

AAC. For arch supports, orthopedic shoes, and other foot devices.

AAD. Benefits for contraceptives, unless specified as a Covered Service in this Policy.

AAE. For cranial prostheses (wigs) and cranial molding helmets.

AAF. For surgical removal of excess skin that is the result of weight loss or gain, including but not limited to association with prior weight reduction (obesity) surgery.

AAG. For the purchase of Therapy or Service Dogs/Animals and the cost of training/maintaining said animals.

II. Preexisting Condition Waiting Period

No benefits are available under this Policy for services, supplies, drugs, or other charges that are provided within twelve (12) months after an Insured's Enrollment Date for any Preexisting Condition.

III. Comprehensive Lifetime Benefit Limit

The Comprehensive Lifetime Benefit Limit for Covered Services is shown in the Benefits Outline and is subject to all of the other provisions of this Policy, including any and all Lifetime Benefit Limits for certain specified Covered Services. However, if an Insured has previously received benefits under one (1) or more agreements, certificates, contracts and/or policies administered by BCI for the Group, the amount of benefits

furnished while enrolled under all such previous agreements, certificates, contracts, and policies will be deducted from the Comprehensive Lifetime Benefit Limit available to the Insured under this Policy. When an Insured has reached his or her Comprehensive Lifetime Benefit Limit, no further benefits shall be owed or paid to the Insured under this Policy or any other agreement, certificate, contract or policy administered by BCI for the Group.

GENERAL PROVISIONS SECTION

I. Entire Policy—Changes

This Policy, which includes only the Benefits Outline, individual enrollment applications, Insured identification cards, and any written endorsements, riders, amendments, or other written agreements approved in writing by an authorized Blue Cross of Idaho (BCI) officer and the State of Idaho (Group), is the entire Policy between the Group and BCI. No agent or representative of BCI, other than a BCI officer, may change this Policy or waive any of its provisions. This Policy supplants and replaces any and all previous oral or written agreements, certificates, contracts, policies or representations, which shall have no further force and effect.

II. Records of Insured Eligibility and Changes in Insured Eligibility

A. The Group shall furnish completed applications or other BCI approved forms required by BCI for it to provide coverage of the Group's Insureds under this Policy. In addition, the Group will provide written notification to BCI within thirty (30) days of the Effective Date of any changes in an Insured's enrollment and benefit coverage status under this Policy.

B. A notification by the Group to BCI must be furnished on BCI approved forms, and according to rules and regulations of BCI. The notification must include all information reasonably required by BCI to effect changes, and must be accompanied by payment of applicable premiums.

III. Termination or Modification of This Policy

A. The Group or BCI may unilaterally terminate or modify the terms of this Policy as required by statutory and/or regulatory changes. Such termination or modification shall be effective immediately or as required by the statutory or regulatory change. BCI shall give the Group written notification of such modification or termination.

B. This Policy may be unilaterally terminated by BCI for any of the following:

1. For the Group's fraud or intentional misrepresentation of a material fact.
2. If BCI elects not to renew all of its Health Benefit Plans delivered or issued for delivery to Large Employers in the state of Idaho. In which case, BCI will provide notice to the Group and its Insureds of such nonrenewal at least one hundred eighty (180) days in advance of the date of nonrenewal.

C. If the Group fails to pay premiums as agreed in the Eligibility and Enrollment Section, this Policy will terminate without notice at the end of the period for which the last premiums were paid. However, if the Group makes premium payments within sixty (60) days after the due date, BCI will reinstate this Policy as of the due date. No benefits are available during this sixty (60)-day period unless all premiums are properly paid before expiration of the sixty (60)-day period.

D. No more than 120 days prior to the date of annual renewal, BCI must provide to the Group a written proposal of renewal rates for the then current benefit plan.

IV. Termination or Modification of an Insured's Coverage Under This Policy

A. If an Enrollee ceases to be an Eligible Employee or the Group does not remit the required premium, the Enrollee's coverage and the coverage of any and all enrolled Eligible Dependents will terminate on the last day of the last month for which payment was made.

B. Except as provided in this paragraph, coverage under this Policy will terminate on the date an Insured no longer qualifies as an Insured, as defined in the Eligibility and Enrollment Section. Coverage will not terminate because of age for an Insured who is an unmarried dependent child incapable of self-sustaining employment by reason of mental handicap or retardation or physical handicap, who became so incapable prior to reaching the age limit, and who is chiefly dependent on the Enrollee for support and maintenance, provided the Enrollee, within thirty-one (31) days of when the dependent child reaches the age limit, has submitted to BCI (at the Enrollee's expense) a Physician's certification of such dependent child's incapacity. BCI may require, at reasonable intervals during the

two (2) years following when the child reaches the age limit, subsequent proof of the child's continuing disability and dependency. After two (2) years, BCI may require such subsequent proof once each year. Coverage for the dependent child will continue so long as this Policy remains in effect, the child's disability and financial dependency exists, and the child has not exhausted benefits.

C. Termination or modification of this Policy automatically terminates or modifies all of the Insured's coverage and rights hereunder. It is the responsibility of the Group to notify all of its Insureds of the termination or any modification of this Policy, and BCI's notice to the Group, upon mailing or any other delivery, constitutes complete and conclusive notice to the Insureds.

D. Except as otherwise provided in this Policy, no benefits are available to an Insured for Covered Services rendered after the date of termination of an Insured's coverage.

E. Prior to legal finalization of an adoption, the coverage provided in this Policy for a child placed for adoption with an Enrollee continues as it would for a naturally born child of the Enrollee until the first of the following events occurs:

1. The date the child is removed permanently from placement and the legal obligation terminates, or
2. The date the Enrollee rescinds, in writing, the agreement of adoption or the agreement assuming financial responsibility.

If one (1) of the foregoing events occurs, coverage terminates on the last day of the month in which such event occurs.

F. Coverage under this Policy will terminate for an Eligible Dependent on the last day of the month he or she no longer qualifies as an Eligible Dependent due to a change in eligibility status.

V. Benefits After Termination of Coverage

A. When this Policy remains in effect but an Insured's coverage terminates for reasons other than those specified in General Provisions IV.E., benefits will be continued:

1. If the Insured is eligible for and properly elects continuation coverage in accordance with the applicable provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any amendments thereto.

   Most employers who employ twenty (20) or more people on a typical business day are subject to COBRA. If the Group is subject to COBRA, an Insured may be entitled to continuation coverage. Insureds should check with the Group for details.
2. For Covered Services of an Insured who is being treated as an Inpatient on the day the Insured's coverage terminates, but only until the Insured is discharged, or the end of the Benefit Period in which coverage terminated, or until benefits are exhausted, whichever occurs first. Benefits for Covered Services are limited to the Inpatient treatment of the condition, Accidental Injury, Disease or Illness causing the Inpatient confinement.

B. When the Group or BCI terminates this Policy, benefits will be continued:

1. For Covered Services of an Insured who is being treated as an Inpatient on the day the Insured's coverage terminates, but only until the Insured is discharged, or the end of the Benefit Period in which coverage terminated, or until benefits are exhausted, whichever occurs first. Benefits for Covered Services are limited to the Inpatient treatment of the condition, Accidental Injury, Disease or Illness causing the Inpatient confinement.
2. For Covered Services directly related to a pregnancy that existed on the date of termination, in accordance with state law and regulations. Such Covered Services are subject to all the terms, limitations, and provisions of this Policy and will be provided for no more than twelve (12) consecutive months following the date coverage terminates or until the conclusion of the pregnancy, or until replacement coverage is in effect according to General Provisions section XXIX. of this Policy, whichever occurs first.
3. For Covered Services directly related to a Total Disability that existed on the date of termination, in accordance with state law and regulations. Such Covered Services are subject to all the terms, limitations, and provisions of this Policy and will be provided for no more

than twelve (12) consecutive months following the date coverage terminates or until the Total Disability ceases, whichever occurs first.

VI. Transfer Privilege

An Insured may be eligible to transfer his or her health care coverage to a BCI individual policy if the Insured ceases to be eligible for coverage under this Policy. If an Insured's enrollment status changes as indicated below, the following Insureds may apply for transfer if the Insured has not reached his or her Comprehensive Lifetime Benefit Limit:

A. The Enrollee, if the Enrollee ceases to be an Eligible Employee as specified in the Eligibility and Enrollment Section. The Enrollee may include enrolled Eligible Dependents in the Enrollee's application for transfer.

B. An enrolled dependent child who ceases to be an Eligible Dependent as specified in the Eligibility and Enrollment Section.

C. The Enrollee's spouse (if an Insured) upon entry of a final decree of divorce or annulment.

D. The Enrollee's enrolled Eligible Dependents upon the Enrollee's death.

To apply for a transfer, the Insured must submit a completed application and the appropriate premium to BCI within thirty (30) days after the loss of eligibility of coverage. If approved, benefits under the new policy are subject to the rates, regulations, terms, and provisions of the new policy.

If the Group or BCI terminates this Policy, and the Group provides another health care plan to its employees effective immediately after the termination of this Policy, no Insured will be entitled to this transfer privilege.

VII. Contract Between BCI and the Group—Description of Coverage

This Policy is a contract between BCI and the Group. BCI will provide the Group with a copy of the Policy This Policy shall not be construed as a contract between BCI and any Enrollee. BCI's mailing or other delivery of this Policy to the Group constitutes complete and conclusive issuance and delivery thereof to each Enrollee.

VIII. Applicable Law

This Policy shall be governed by and interpreted according to the laws of the state of Idaho. BCI and the Group consent to the jurisdiction of the state courts of Ada County in the state of Idaho in the event of any dispute between them. The rights of the Insureds and coverage under this Policy may be affected by applicable state and federal laws, including without limitation the Health Insurance Portability and Accountability Act.

IX. Notice

Any notice required under this Policy must be in writing. BCI's notices to the Group will be sent to the Group's address as it appears on BCI's records, and mailing or delivery to the Group constitutes complete and conclusive notice to the Insureds. Notice given to BCI must be sent to BCI's address contained in the Group Application. The Group shall give BCI immediate written notice of any change of address for the Group or any of its Insureds. BCI shall give the Group immediate written notice of any change in BCI's address. When BCI is required to give advice or notice, the depositing of such advice or notice with the U.S. Postal Service, regular mail, or the other delivery conclusively constitutes the giving of such advice or notice on the date of such mailing or delivery.

X. Benefits to Which Insureds are Entitled

A. Subject to all of the terms of this Policy, an Insured is entitled to benefits for Covered Services in the amounts specified in the benefit sections and/or in the Benefits Outline.

B. In the event of an Inpatient Admission that occurs prior to the Group's transfer to BCI and the Effective Date of coverage under this Policy, benefits will be provided only when the Insured receives services that are Covered Services under this Policy. The outgoing carrier has primary responsible for providing benefits for the Inpatient treatment from the date of admission until the first of the following events occur:

- The Insured is discharged,

- The Benefit Period under the previous coverage ends, or
- Until benefits under the outgoing carrier's policy are exhausted.

BCI will provide benefits for Covered Services incurred following the Effective Date of coverage reduced by the benefits paid by the outgoing carrier.

C. Benefits will be provided only if Covered Services are prescribed by, or performed by, or under the direction of a Physician or other Professional Provider.

D. Benefits for Covered Services specified in this Policy are provided only for Covered Services that are rendered by the Covered Providers specified in the benefits sections of this Policy and that are regularly and customarily included in such Covered Providers' charges.

E. Covered Services are subject to the availability of Licensed General Hospitals and other Facility Providers and the ability of the employees of such Providers and of available Physicians to provide such services. BCI shall not assume nor have any liability for conditions beyond its control which affect the Insured's ability to obtain Covered Services.

XI. Notice of Claim

BCI is not liable under this Policy to provide benefits unless a proper claim is furnished to BCI that shows Covered Services have been rendered to an Insured. A claim must be provided within one (1) year from the date a Covered Service is rendered. The claim must include all the data necessary for BCI to determine benefits.

XII. Release and Disclosure of Medical Records and Other Information

In order to effectively apply the provisions of this Policy, BCI may obtain information from Providers and other entities pertaining to any health related services that the Insured may receive or may have received in the past. BCI may also disclose to Providers and other entities, information obtained from the Insured's transactions such as policy coverage, premiums, payment history and claims data necessary to allow the processing of a claim and for other health care operations. To protect the Insured's privacy, BCI treats all information in a confidential manner. For further information regarding BCI's privacy policies and procedures, the Insured may request a copy of BCI's Notice of Privacy Practices by contacting customer service at the number provided in this Policy.

Each Insured also authorizes disclosures to the employer, association, trust fund, union, or similar entity to which this Policy is issued for purposes of utilization review or audit and such other disclosures as may be permitted or required by law.

XIII. Exclusion of General Damages

Liability under this Policy for benefits conferred hereunder, including recovery under any claim or breach of this Policy, is limited to the actual benefits for Covered Services as provided herein and shall specifically exclude any claim for general damages, including but not limited to, alleged pain, suffering or mental anguish, or for economic loss, or consequential loss or damages.

XIV. Payment of Benefits

A. The Insured authorizes BCI to make payments directly to Providers rendering Covered Services to the Insured for benefits provided under this Policy. Notwithstanding this authorization, BCI reserves and has the right to make such payments directly to the Insured. Except as provided by law, BCI's right to pay an Insured directly is not assignable by an Insured nor can it be waived without BCI's concurrence nor may the right to receive benefits for Covered Services under this Policy be transferred or assigned, either before or after Covered Services are rendered.

B. Once Covered Services are rendered by a Provider, BCI is not obligated to honor Insured requests not to pay claims submitted by such Provider, and BCI shall have no liability to any person because of its rejection of such request. However, for good cause and in its sole discretion, BCI may nonetheless deny all or any part of any Provider claim.

XV. Insured/Provider Relationship

A. The choice of a Provider is solely the Insured's.

B. BCI does not render Covered Services but only makes payment for Covered Services received by Insureds. BCI is not liable for any act or omission or for the level of competence of any Provider, and BCI has no responsibility for a Provider's failure or refusal to render Covered Services to an Insured.

C. The use or nonuse of an adjective such as Contracting or Noncontracting is not a statement as to the ability of the Provider.

XVI. Participating Plan

BCI may, in its sole discretion, make an agreement with any appropriate entity (referred to as a Participating Plan) to provide, in whole or in part, benefits for Covered Services to Insureds, but it shall have no obligation to do so.

XVII. Coordination of This Policy's Benefits With Other Benefits

A. Applicability

1. This Coordination of Benefits (COB) provision applies to This Contract when an Insured has health care coverage under more than one (1) Contract. "Contract" and "This Contract" are defined below.
2. If this COB provisions applies, the order of benefit determination rules are looked at first. Those rules determine whether the benefits of This Contract are determined before or after those of other Contracts. The benefits of This Contract:
   a) Shall not be reduced when, under the order of benefit determination rules, This Contract determines its benefits before another Contract; but
   b) May be reduced when, under the order of benefit determination rules, another Contract determines its benefits first. The above reduction is described in Paragraph D. "Effect on the Benefits of This Contract."

B. Definitions

The following definitions apply to this Coordination of Benefits provision:

1. "Contract" is any of one (1) of the following that provides benefits or services for, or because of, medical, or dental care or treatment:
   a) Individual or family insurance, group insurance or group-type coverage, whether insured or uninsured, whether closed or nonclosed panel plans. This includes prepayment, group practice, individual practice, or group/group-type hospital indemnity benefits coverage that exceed two hundred dollars ($200) per day. It also includes coverage other than school accident-type coverage.
   b) Coverage under a long-term care contract for medical care components.
   c) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

   "Contract" shall not include:
   a) Group or group-type hospital indemnity benefits of two hundred dollars ($200) per day or less.
   b) School accident-type coverages. These contracts cover students for accidents only, including athletic injuries, either on a twenty-four (24) hour basis or on a "to and from school" basis.
   (c) Benefits provided in long-term care insurance policies for non-medical service; for example, personal care, adult daycare, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay as fixed daily benefit without regard to expenses incurred or the receipt of services.
   (d) Medical benefits coverage in individual automobile "no fault" and traditional automobile "fault" type contracts.

(e) Limited benefit health coverages, such as, but not limited to, accident only, specified disease, disability income, hospital indemnity, credit insurance benefits, dental insurance, vision insurance; coverages issued to supplement liability insurance; and worker's compensation or similar insurance.
(f) Medicare supplement policies.
(g) A state plan under Medicaid.
(h) A governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
(i) Nonrenewable short-term coverages issued for a period of twelve (12) months or less.

Each Contract or other arrangement for coverage under a) through c) is a separate Contract. Also, if an arrangement has two (2) parts and COB rules apply only to one (1) of the two (2), each of the parts is a separate Contract.

2. "This Contract" means this specific Policy with the Group.
3. "Primary Contract/Secondary Contract": The order of benefit determination rules state whether This Contract is a Primary Contract or Secondary Contract as to another Contract covering the Insured.
   a) When This Contract is a Primary Contract, its benefits are determined before those of the other Contract and without considering the other Contract's benefits.
   b) When This Contract is a Secondary Contract, its benefits are determined after those of the Other Contract and may be reduced because of the other Contract's benefits.
   c) When there are more than two (2) Contracts covering the person, This Contract may be a Primary Contract as to one (1) or more other Contracts, and may be a Secondary Contract as to a different Contract or Contracts.
4. "Closed Panel Plan" means a managed care organization (MCO), preferred provider organization (PPO), exclusive provider organization (EPO), managed care, point of service plan, or other plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
5. "Allowable Expenses" means a necessary, reasonable and customary item of expense for health care including Deductibles, Coinsurance or Copayments, when the item of expense is covered at least in part by one (1) or more Contracts covering the person for whom the claim is made.
   a) When a Contract provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and benefit paid.
   b) When benefits are reduced under a Primary Contract because a covered person does not comply with the Contract provisions, the amount of such reduction will not be considered an Allowable Expense.
   c) When a Primary Contract is a closed panel plan and the Secondary Contract is not a closed panel plan, the Secondary Contract will pay or provide benefits as if it were primary when a covered person used a nonpanel provider, except for emergency services or authorized referrals that are paid or provided by the Primary Contract.
6. "Claim Determination Period" means a Benefit Period. However, it does not include any part of a year during which an Insured has no coverage under This Contract.

C. Order of Benefit Determination Rules

1. General. When there is a basis for a claim under This Contract and another Contract, the order of benefit payments is as follows:
   a) The Primary Contract must pay or provide its benefits as if the Secondary Contract or Contracts did not exist.
   b) A Contract that does not contain order of benefit determination rules consistent with This Contract's rules shall be Primary. The only exceptions are:
      (1) Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplemental coverage is excess to any other parts of the Contract

provided by the policyholder.

(2) An individual Contract is always secondary to a group Contract.

c) A Contract may consider the benefits paid or provided by another Contract only when it is secondary to that other Contract.

2. Rules. This Contract determines its order of benefits using the first of the following rules that applies:

a) Group/Individual Contract. The benefits of the Contract that covers the person within a group Contract are determined before those of the Contract that covers the person on an individual Contract.

b) Non-Dependent/Dependent. The benefits of the Contract that covers the person as an employee, Insured, or retiree (that is, other than as a dependent) are determined before those of the Contract that covers the person as a dependent. However, if the person is a Medicare beneficiary and, as a result of the provisions of Title XVIII of the Social Security Act and implementing rules, Medicare is:

(1) Secondary to the Contract covering the person as a dependent; and

(2) Primary to the Contract covering the person as other than a dependent (e.g., a retired employee) then the order of benefits is reversed so that the Contract covering the person as an employee, Insured, or retiree, is secondary and the other Contract is primary.

c) Dependent Child/Parents not Separated or Divorced. Except as stated in Subparagraph 2.d) below, when This Contract and another Contract cover the same child as a dependent of different persons, called “parents”:

(1) The benefits of the Contract of the parent whose birthday falls earlier in a year are determined before those of the parent whose birthday falls later in that year; but

(2) If both parents have the same birthday, the benefits of the Contract that covered one (1) parent longer are determined before those of the Contract that covered the other parent for a shorter period of time.

d) Dependent Child/Separated or Divorced. If two (2) or more Contracts cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order;

(1) First, the Contract of the parent with custody of the child.

(2) Then, the Contract of the spouse of the parent with custody of the child.

(3) Then, the Contact of the parent not having custody.

(4) Finally, the Contract of the spouse of the parent not having custody of the child.

However, if the specific terms of a court decree state that one (1) of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Contract of that parent has actual knowledge of those terms, the benefits of that Contract are determined first. The Contract of the other parent shall be the Secondary Contract. This paragraph does not apply with respect to any Claim Determination Period or Contract year during which any benefits are actually paid or provided before the entity has that actual knowledge.

e) Active/Inactive Eligible Employee. The benefits of a Contact that covers a person as an employee who is neither laid off nor retired (or as that employee’s dependent) are determined before those of a Contract that covers that person as a laid off or retired employee (or as that employee’s dependent). If the other Contract does not have this rule, and if, as a result, the Contracts do not agree on the order of benefits, this Rule e) is ignored. Coverage provided an individual as a retired worker and as a dependent of that individual’s spouse as an active worker are determined under the Non-Dependent/Dependent rule b).

f) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the Contracts covering the child shall follow the order of benefit determination rules outlined in Subparagraph C.2.c) above.

g) Continuation Coverage. The benefits of a Contract that covers a person as an

employee or retiree (or as that person's dependent) are determined before those of a Contract that covers a person pursuant to federal or state law under a right of continuation. If the other Contract does not have this rule, and if, as a result, the Contracts do not agree on the order of benefits then Rule g), is ignored.

h) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Contract that covered an Insured longer are determined before those of the Contract that covered that person for the shorter term.

i) If none of these rules determines the Primary Contract, the allowable expenses will be shared equally between the Contracts.

D. Effect on the Benefits of This Contract

1. When This Paragraph Applies. This Paragraph D. applies when, in accordance with Paragraph C., "Order of Benefit Determination Rules," This Contract is a Secondary Contract as to one (1) or more other Contracts. If the benefits of This Contract may be reduced under this paragraph, such other Contract or Contracts are referred to as "the other Contracts" in subparagraph 2. immediately below.
2. Reduction in This Contract's Benefits. The benefits of This Contract will be reduced when the sum of:
   a) The benefits that would be payable for the Allowable Expense under This Contract in the absence of this COB provision.
   b) The benefits that would be payable for the Allowable Expense under the other Contracts, in the absence of provisions with a purpose like this COB provision (whether or not claim is made) exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Contract will be reduced so that they and the benefits payable under the other Contracts do not total more than those Allowable Expenses.

   When the benefits of This Contract are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Contract.

E. Facility of Payment

A payment made under another Contract may include an amount, which should have been paid under This Contract. If it does, BCI may pay that amount to the organization that made the initial payment and that amount will be treated as though it was a benefit paid under This Contract. BCI will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

F. Right of Recovery

If the amount of payments made by BCI is more than it should have paid under this COB provision, it may recover the excess from one (1) or more of:

1. The persons it has paid or for whom it has paid.
2. Insurance companies.
3. Other organizations.

XVIII. Benefits for Medicare Eligibles Who are Covered Under This Policy

A. If the Group has twenty (20) or more employees, any Eligible Employee or spouse of an Eligible Employee who becomes or remains an Insured of the Group covered by this Policy after becoming eligible for Medicare (due to reaching age sixty-five (65)) is entitled to receive the benefits of this Policy as primary, unless such Insured elects Medicare as his or her primary coverage. The Group must notify BCI in writing of any Insured's election. Any Insured who elects Medicare as primary is not eligible for coverage under this Policy as of the date of such election.

B. If the Group has one hundred (100) or more employees or the Group is an organization which includes an employer with one hundred (100) or more employees, any Eligible Employee, spouse of an Eligible Employee or dependent child of an Eligible Employee who becomes or remains an Insured of the Group covered by this Policy after becoming eligible for Medicare due to disability is entitled

to receive the benefits of this Policy as primary, unless such Insured elects Medicare as his or her primary coverage. The Group must notify BCI in writing of any Insured's election. Any Insured who elects Medicare as primary is not eligible for coverage under this Policy as of the date of such election.

C. An Insured eligible for Medicare based solely on end stage renal Disease is entitled to receive the benefits of this Policy as primary for eighteen (18) months only, beginning with the month of Medicare entitlement, if Medicare entitlement is effective before March 1, 1996. If Medicare entitlement is effective on or after March 1, 1996, the Insured is entitled to receive the benefits of this Policy as primary for thirty (30) months only, beginning with the month of Medicare entitlement.

XIX. Indemnity by the Group and Blue Cross of Idaho

Anything contained in this Policy notwithstanding, including any limitation on damages, the Group and BCI agree to defend, indemnify and hold harmless the other from and against any claim, demand, expense, loss, damage, cost, judgment, fee or liability the other receives, incurs or sustains that is caused by or arises out of any negligent act or omission of the indemnifying party related to this Policy. The indemnification obligation of the Group is subject to the limitations of the Idaho Tort Claims Act, including dollar amounts.

XX. Incorporated by Reference

All of the terms, limitations and exclusions of coverage contained in this Policy are incorporated by reference into all sections, endorsements, riders, and amendments and are as effective as if fully expressed in each one unless specifically noted to the contrary.

XXI. Inquiry and Appeals Procedures

A. Informal Inquiry

For any initial questions concerning a claim, an Insured should call or write BCI's Customer Services Department. BCI's phone numbers and addresses are listed on the Explanation of Benefits (EOB).

B. Formal Appeal

An Insured who wishes to formally appeal a Pre-Service Claim decision by BCI may do so through the following process:

1. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. Urgent claim appeals, and the documents in support of such appeals may be submitted by phone or facsimile. The appeal should set forth the reasons why the Insured contends BCI's decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.
2. After receipt of the appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed. For non-urgent claim appeals, BCI will mail a written reply to the Insured within fifteen (15) days after receipt of the written appeal. Urgent claim appeals will be notified orally within seventy-two (72) hours. If the original decision is upheld, the reply will state the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible taking into account the medical exigencies of each claim.
3. Furthermore, the Insured or their authorized representative has the right to reasonable access to, and copies of all documents, records, and other information that are relevant to the appeal.
4. If the original, non-urgent claim decision is upheld upon reconsideration, the Insured may send an additional written appeal to the Appeals and Grievance Coordinator requesting further review. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within thirty (30) days of BCI's mailing of the initial reconsideration decision. The Appeals and Grievance Coordinator will issue a final decision after consideration of all relevant information. A final decision on the appeal will be made within fifteen (15) days of its receipt.

C. An Insured who wishes to formally appeal a Post-Service Claims decision by BCI may do so through the following process:

1. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred

eighty (180) days after receipt of the notice of Adverse Benefit Determination. This written appeal should set forth the reasons why the Insured contends BCI's decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.

2. After receipt of the written appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed. BCI shall mail a written reply to the Insured within thirty (30) days after receipt of the written appeal. If the original decision is upheld, the reply will list the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible.
3. Furthermore, the Insured or their authorized representative has the right to reasonable access to, and copies of all documents, records, and other information that are relevant to the appeal.
4. If the original decision is upheld upon reconsideration, the Insured may send an additional written appeal to the Appeals and Grievance Coordinator requesting *further review*. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within sixty (60) days of BCI's mailing of the initial reconsideration decision. The Appeals and Grievance Coordinator will issue a final decision after consideration of all relevant information. A final decision on the appeal will be made within thirty (30) days of its receipt.

D. External Review

At BCI's discretion, an additional review is available for Adverse Benefit Determinations based upon medical issues including medical necessity and investigational treatment. An Insured must first exhaust both levels of the formal appeals process before submitting a request for External Review to the Appeals and Grievance Coordinator. A request for External Review must be sent within sixty (60) days of the date of BCI's second formal written appeal decision. External Review will be made by an impartial provider, associated with an independent review organization, who practices in the same or a similar specialty as the one involved in the review. The Independent Review Organization will issue a determination within sixty (60) days of receipt of the request for External Review.

Submission of an appeal for External Review is voluntary and does not affect an Insured's right to file a civil action under section 502(a) of the Employee Retirement Income Security Act (ERISA) following the exhaustion of the formal appeals process, except that the time to file such action shall be tolled while the External Review is pending.

XXII. Plan Administrator—COBRA

BCI is not the plan administrator for compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any amendments to it. Except for services BCI has agreed to perform regarding COBRA, the Group is responsible for satisfaction of notice, disclosure, and other obligations if these laws are applicable to the Group.

XXIII. Reimbursement of Benefits Paid by Mistake

If BCI mistakenly pays benefits on behalf of an Enrollee or his or her Eligible Dependent(s) that the Enrollee or his or her Eligible Dependent(s) is not entitled to under this Policy, the Enrollee must reimburse the erroneous benefits to BCI.

The reimbursement is due and payable as soon as BCI notifies the Enrollee and requests reimbursement. BCI may also recover such erroneous benefits from any other person or Provider to whom the payments were made. If reimbursement is not made in a timely manner, BCI may reduce benefits or reduce an allowance for benefits as a set-off toward reimbursement.

Even though BCI may elect to continue to provide benefits after mistakenly paying benefits, BCI may still enforce this provision. This provision is in addition to, not instead of, any other remedy BCI may have at law or in equity.

XXIV. Subrogation Rights and Obligations of Blue Cross of Idaho

A. The benefits of this Policy will be available to an Insured when he or she is injured, suffers harm or incurs loss due to any act, omission, or defective or unreasonably hazardous product or service of another person, firm, corporation or entity (hereafter referred to as "third party"). To the extent that such benefits for Covered Services are provided or paid for by BCI under this Policy or any other BCI agreement, certificate, contract or policy, BCI shall be subrogated and succeed to the rights of the Insured or, in the event of the Insured's death, to the rights of his or her heirs, estate and/or personal representative. Termination of the Policy by the Group or BCI does not affect the subrogation rights or obligations of BCI. Upon any such termination, BCI shall retain responsibility for all aspects of subrogation of all claims related to or arising under this Policy.

B. As a condition of receiving benefits for Covered Services in such an event, the Insured or his or her personal representative will give BCI (in writing) the names and addresses of the third party or parties that caused or are responsible, or may have caused or may be responsible for such injury, harm, or loss, and all facts and information known to the Insured concerning the injury, harm or loss. The Insured must fully cooperate with BCI in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm, or loss and shall do nothing whatsoever to prejudice BCI's Subrogation Rights and efforts.

C. The Insured must pay to BCI all amounts recovered by suit, settlement, or otherwise from any third party or parties or from any third party or parties' insurer(s), indemnitor(s), or underwriter(s), to the extent of benefits provided by BCI under this Policy. BCI's Subrogation Rights take priority over the Insured's rights both for expenses already incurred and paid by BCI for Covered Services, and for benefits to be provided or payments to be made by BCI in the future on account of the injury, harm, or loss giving rise to BCI's Subrogation Rights. Further, BCI's Subrogation Rights to reimbursement and/or recovery for incurred expenses and/or future expenses yet to be incurred are primary and take precedence over the rights of the Insured, even if there are deficiencies in recovery or insufficient financial resources available to the third party or parties to totally satisfy all of the claims and judgments of the Insured and BCI. BCI may elect to enforce its Subrogation Rights by initiating litigation on its own behalf and, in its sole discretion, in the name of the Insured against any third party or parties.

D. Collections or recoveries made in excess of such incurred BCI expenses will first be allocated to such future BCI expenses, and will constitute a special Deductible applicable to such future benefits and services under this or any subsequent BCI Policy. Thereafter, BCI shall have no obligation to make any further payment or provide any further benefits until benefits equal to the special Deductible have been incurred, delivered, and paid by the Insured.

XXV. Independent Blue Cross and Blue Shield Plans

The Group (on behalf of itself and its participants), hereby expressly acknowledges its understanding this Policy constitutes a contract solely between the Group and BCI, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCI to use the Blue Cross and Blue Shield Service Marks in the state of Idaho, and that BCI is not contracting as the agent of the Association. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Policy based upon representations by any person, entity, or organization other than BCI and that no person, entity, or organization other than BCI shall be held accountable or liable to the Group for any of BCI's obligations to the Group created under this Policy. This paragraph shall not create any additional obligations whatsoever on the part of BCI other than those obligations created under other provisions of this Policy or by applicable law.

XXVI. Statements

In the absence of fraud, all statements made by an applicant, or the policyholder, or by an enrolled person shall be deemed representations and not warranties, and no statement made for the purpose of acquiring insurance shall void such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the enrolled person.

XXVII. Membership, Voting, Annual Meeting and Participation

The Group, as the policyholder, is a member of BCI and is entitled to vote in person or by proxy at the meetings of policyholders. The Group shall designate to BCI in writing the person who has the right to vote in person or by proxy on behalf of the Group. The annual meeting of policyholders of BCI is held on the last Friday of April of each year at 2:00 p.m., at the corporation's registered office, 3000 East Pine Avenue, Meridian, Idaho. This notice shall be sufficient as to notification of such annual meetings. If any dividends are distributed, the policyholders shall share in them according to the articles of incorporation and bylaws of BCI and under the conditions set by the board of directors of BCI.

XXVIII. BlueCard Payment Calculations

A. Employer Information

Like all Blue Cross and Blue Shield Licensees, BCI participates in a program called "BlueCard." Whenever Insureds access health care services outside the geographic area BCI serves, the claim for those services may be processed through BlueCard and presented to BCI for payment in conformity with network access rules of the BlueCard Policies then in effect ("Policies"). Under BlueCard, when Insureds receive Covered Services within the geographic area served by an on-site Blue Cross and/or Blue Shield Licensee ("Host Blue"), BCI will remain responsible to the Group for fulfilling BCI contract obligations. However, the Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing services such as contracting with its participating Providers and handling all interaction with its participating Providers. The financial terms of BlueCard are described generally below.

1. **Liability Calculation Method per Claim**

The calculation of Insured liability on claims for Covered Services incurred outside the geographic area BCI serves and processed through BlueCard, if not covered by a flat dollar copayment, will be based on the lower of the Provider's billed charges or the negotiated price BCI pays the Host Blue. The methods employed by a Host Blue to determine a negotiated price will vary among Host Blues based on the terms of each Host Blue's Provider contracts. The negotiated price paid to a Host Blue by BCI on a claim for health care services processed through BlueCard may represent:

a) the actual price paid on the claim by the Host Blue to the health care Provider ("Actual Price"); or

b) an estimated price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Blue's health care Providers or one or more particular Providers ("Estimated Price"); or

c) an average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its Providers or for a specified group of Providers ("Average Price").

An Average Price may result in greater variation to the Insured and the Group from the Actual Price than would an Estimated Price. Host Blues using either the Estimated Price or an Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over- or underestimation of past prices. However, the amount paid by the Insured is a final price and will not be affected by such prospective adjustment.

Statutes in a small number of states may require a Host Blue either (1) to use a basis for calculating Insured liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (2) to add a surcharge. If any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, BCI would then calculate Insured liability for any Covered Services consistent with the applicable Host Blue state statute in effect at the time the Insured received those services.

2. **Return of Overpayments**
Under BlueCard, recoveries from a Host Blue or from participating Providers of a Host Blue can arise in several ways, including but not limited to anti-fraud and abuse audits, Provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Policies, which generally require correction on a claim-by-claim or prospective basis.

B. Employee Information
Under BlueCard, when you obtain health care services outside the geographic area BCI serves, if not covered by a flat dollar copayment, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to us.

Often, this "negotiated price" will consist of a simple discount that reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for overestimation or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Insured liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. If any state statutes mandate Insured liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, BCI will then calculate your liability for any Covered Services in accordance with the applicable Host Blue state statute in effect at the time you received your care.

XXIX. Replacement Coverage
If this Policy replaces prior Group coverage within sixty (60) days of the date of termination of prior coverage, BCI shall immediately cover all employees and dependents validly covered under the prior coverage at the date of termination who meet the Group's eligibility requirements and who would otherwise be eligible for coverage under this Policy, regardless of any exclusions or limitations relating to active employment or nonconfinement.

The previous paragraph is subject to all other provisions of Idaho Code Section 41-2215, including BCI's right to deduct from any benefits becoming payable under this Policy the amount of benefits under the prior Group coverage pursuant to an extension of benefits provision for Insureds who are Totally Disabled.

XXX. Individual Benefits Management
Individual Benefits Management allows BCI to provide alternative benefits in place of specified Covered Services when alternative benefits allow the Insured to achieve optimum health care in the most cost-effective way.

The decision to allow alternative benefits will be made by BCI in its sole and absolute discretion on a case-by-case basis. BCI may allow alternative benefits in place of specified Covered Services when an Insured, or the Insured's legal guardian and his or her Physician concur in the request for and the advisability of alternative benefits. BCI reserves the right to modify, limit, or cease providing alternative benefits at any time.

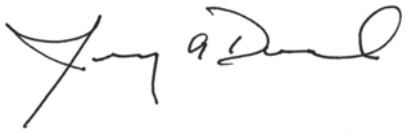
A determination to cover alternative benefits for an Insured shall not be deemed to waive, alter, or affect BCI's right to reject any other requests or recommendations for alternative benefits.

XXXI. Coverage and Benefits Determination

BCI is vested with authority and discretion to determine whether a claim for benefits is covered under the terms of this Policy, based on all the terms and provisions set forth in this Policy, and also to determine the amount of benefits owed on claims which are covered.

In witness whereof, BLUE CROSS OF IDAHO HEALTH SERVICE, INC., by its duly authorized officer, has executed this Policy.

Blue Cross of Idaho
Health Service, Inc.
PO Box 7408
Boise, ID 83707



Jerry A. Dworak
Sr. VP & Chief Marketing Officer

PRENATAL EDUCATION PROGRAM ENDORSEMENT

Bright Beginnings is a prenatal program designed to promote healthy prenatal care through education to expectant mothers. Blue Cross of Idaho provides this program to any employee, or their spouse, who is pregnant. Program members are provided with nutrition, exercise, prenatal care, and child care information to help maintain a health pregnancy and to deliver a health baby.

Enrolling in the Program

An expectant woman who wishes to participate in the Bright Beginnings program must enroll during the first three- (3) months (the first trimester) of her pregnancy. Simply call Bright Beginnings at (208) 387-6999.

The Program Includes

Upon enrollment, the expectant mother will receive a book on pregnancy care as a gift from Blue Cross of Idaho. The gift will be mailed to the expectant mother along with a prenatal card, which is used for the incentive portion of the program. The physician must sign the prenatal card at each prenatal visit and the six- (6) week postpartum examination. When the card is completed, the mother has 60 days to return the card to Blue Cross of Idaho and indicate which of the following she would like to receive as her incentive gift:

- A $100 U.S. Savings Bond in the mother's name; or
- Reimbursement up to $50 toward the purchase of a car seat (if this gift is selected, the purchase receipt for the car seat should be mailed with the completed prenatal card to Blue Cross of Idaho).

Remember

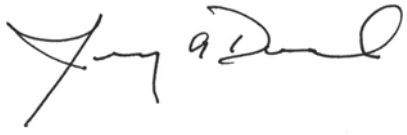
The first step is to call Bright Beginnings at (208) 387-6999. The expectant mother must register for the program and see her physician during the first three- (3) months of her pregnancy in order to be eligible for the selected incentive gift.

Important Note

This program should not be construed to replace prenatal medical care. All treatment decisions about medical care rest exclusively with the expectant mother and her physician. The Bright Beginnings program does not grant, or change, any health care policy coverage. All claims submitted to Blue Cross of Idaho will be administered in accordance with the applicable health care policy.

This endorsement is attached to and forms part of the Policy issued to the Group and shall be effective on the Group's Policy Date.

Blue Cross of Idaho
Health Service, Inc.
PO Box 7408
Boise, ID 83707



Jerry A. Dworak
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